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THE CHAPLAIN'S MINISTRY TO HOSPITAL PATIENTS

HEADQUARTERS, DEPARTMENT OF THE ARMY

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The chaplain's ministry to
hospital patients

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SECTION I
INTRODUCTION

1. Purpose

Throughout his career the Army Chaplain has a recurrent obligation to minister to the hospitalized. Whether or not he is assigned to a military hospital as a member of the staff, he will be required, from time to time, to do some of his work within the hospital. This pamphlet is designed to assist him in developing his effectiveness in pastoral work with the hospitalized.

Recent experiences in the clinical training of clergymen have made clear the need for the chaplain to continue to evaluate his work with hospital patients if he is to be of maximum benefit to them. A pamphlet designed to assist in such an evaluation seemed necessary.

The pamphlet proceeds from matters of interest to all Army Chaplains to a consideration of specialized matters involving the hospital chaplain primarily. The material included is designed to help chaplains in their work not only with the patients, but also with other members of the hospital staff.

2. Scope

To accomplish its purpose as indicated, the scope of this pamphlet is quite broad. It includes matters as basic as making a hospital call, and as specialized as certain problems which arise as a necessary part of hospitalization.

The pamphlet includes a study of problems ordinarily met within a general medical ward, a surgical ward, and other wards which are a part of most hospitals. Specific suggestions are made for coping with these problems.

There is no material dealing specifically with the requirements of various denominations regarding rites an sacraments for the sick and the dying. Such matters are of vital importance, but the inclusion of material comprehensive enough to be a safe guide to follow is not within the scope of this pamphlet. The need for the provision for the full religious coverage of all patients is underlined and the matter of referral is dealt with.

Advice on how to function effectively as a part of the therapeutic team is included in the pamphlet. To assist in such work

a brief consideration of factors involved in the role of the doctor, the nurse, and other personnel working directly with the patients is incorporated.

Finally, the pamphlet includes a statement of personal qualifications considered necessary for effective hospital work. The pamphlet is intended to be helpful to supervisory personnel in the training of other chaplains, but should also assist the individual chaplain who must work alone, and who wishes to improve his skills in the interest of the people he serves.

SECTION II
THE HOSPITAL CALL

3. Introduction

"Do no harm" is a deceptively simple rule governing the work of the medical profession; it also can be a good rule for the clergy. It requires some knowledge of technique to make an effective hospital call. Chaplains can learn to avoid being harmful, and only when they have learned this first lesson, can they learn to be helpful. A few words of advice can help the chaplain avoid the pitfalls that many tend to stumble into despite years of experience in the ministry. It is important that certain basic dangers be avoided so that a chaplain may then become truly helpful.

4. Visiting the Ill

There are certain rules in hospital visiting which are ignored daily by well-meaning clergymen. The rules, or guides, that are here enumerated have been found helpful in the training of hospital chaplains.

a. Check with the nurse in charge of the ward, or with her authorized representative, before visiting a patient. Such a contact is a matter of courtesy to begin with, but it can also be helpful to the chaplain. The chaplain can learn if there have been any changes in the condition of the patient, if there have been any treatment innovations, or if there are any know problems with which he might be able to help.

b. If the patient is in a room with the door closed, the chaplain should knock and identify himself and the nature of his call. This rule should be followed even though the chaplain has just received permission from the ward nurse to make the visit. There is a real reason for such identification. A patient in a hospital becomes wary of all visits. Visits have meant painful experiences; therefore, he is conditioned to respond negatively to any new guest. If the caller immediately identifies himself as a chaplain who wants to visit for a few minutes, the patient then knows what to expect. The unknown causes many difficulties for hospital patients. What the chaplain can do to make the unknown become the known may be helpful.

c. Observe carefully the setting and the situation with regard to the patient. Much can be learned by careful observation either in a private room or out in the open ward. If, for instance, there are no pictures or "get well" messages displayed on the night-stand or bureau, it may mean that the patient is lonely. It might also simply mean that he has just arrived and has had no time to receive word from family or friends. If a woman patient has no makeup on and her hair is straggly, it is a fair indication that her morale is low. The chaplain can also notice any hospital equipment in use by the side of or under the bed and avoid inadvertently disturbing it and alarming the patient. A quick glance can tell a trained hospital chaplain much about the situation which others have to spend some time in discovering.

d. Take a position making it easy for the patient to see you and talk to you. Ordinarily, the chaplain should not sit down unless he is asked to, but there may be times when it would be better for the patient for his visitor to pull up a chair and sit down. If the patient cannot turn his head for any reason, the chaplain should take a position on the patient's line of sight. The chaplain should never sit or stand so that the patient has to stare into the light. When visiting a patient who must lie flat on his back, it is better to stand near the bed, leaning slightly over the patient, so that he can see you easily. If the chaplain follows the rule to observe the situation carefully, he will find the answer to the question of where to sit or stand in relation to the patient.

e. Speak in normal tones. Do not talk loudly. Speak so that the patient can hear you without straining.

f. Say only what you want the patient to hear. Do not whisper near the patient. Even if the patient is delirious or too weak to talk or register knowledge of your presence, say only what you want him to hear. Often the patient's hearing is quite sensitive to even a faintly whispered word about his condition. Don't take that chance.

g. Don't touch, lean against, or sit upon the patient's bed. Sometimes the chaplain feels the friendly thing is to lean on the foot of the patient's bed, or to sit on the edge of it. When the chaplain does so he forgets about the added sensitivity of the sick to any sort of movement. The sick person does not want to be jiggled in any way. Any shaking of the bed, however slight, may add to the patient's pain, or may alarm him as to the possibility that he will be hurt. Don't add to his discomfort.

h. Be brief. Unless there is a specific reason, such as the performance of a religious rite for which the patient has asked,

never stay longer than 15 minutes. Five minutes would be better. One other possible reason for a longer stay would be where a counseling relationship has developed and the patient has demonstrated both his need and his ability to tolerate such a call.

i. Call often. A continuing contact is often more helpful than one or two prolonged calls. Call often, but don't stay long.

j. Don't play doctor. Know the meaning of medical terminology, but do not use it to the patient or to the doctor. You could be wrong and could mislead the patient. You could also lead the doctor to believe you are trying to take over his work.

k. Concentrate on the patient's feelings, not his physical condition. A good way to begin talking to a new patient is simply to inquire, "How are things going?" The patient can then answer the question on any level he chooses. If he wishes to talk about his physical condition, he can. If he wants to tell you about a visit from his mother, he can. Or if he wants to tell you about a problem concerning his religious welfare, he can. The medical personnel are going to inquire about his physical problems several times a day. Let him know that you are there for a different reason. Avoid asking the medical questions. Leave that to the doctor.

l. Accept the patient's feelings as he states them. Do not respond to his announced mood of despair by contradicting him with an optimistic clichê. Let the patient feel as he feels, and let him talk about it on his own terms.

m. Be a chaplain—not an errand boy. As a clergyman, the chaplain has resources which can help a person change his attitudes. As an errand boy, the chaplain can only carry out the patient's request. Don't deny him help, but refer his request to the proper person, whether it is the Red Cross worker or a friend within the patient's unit. An occasional deviation from this rule may not be harmful, but do not let it become a practice. The chaplain is likely to be used in accordance with the value he places upon himself and his ministry.

n. Pray only if it is indicated. Don't use prayer as a mechanical means of closing a conversation. Make sure you do not devalue prayer by using it lightly. There are certain signs for which to watch:

(1) Has the patient been using the language of religion?
(2) Has the patient accepted you as a clergyman?
(3) Is the patient facing surgery or some other traumatic event?

Any one of the signs for prayer may justify its use. Any two of them make prayer mandatory.

o. When you are ready to leave, leave! It is confusing to the patient to tell him that you guess you'd better go, and then fail to do so. If you have to go, stand up, tell him that you have to go, and then leave.

p. Do not tell the patient you'll see him later unless you definitely plan to and can tell him when to expect you. Your relationship with the patient and, therefore, your ability to help him, may be endangered by what the patient interprets as a forgotten appointment.

q. Don't let any rules, even these, become rigid. Be ready to adapt to meet the demands of each new situation. A hospital ministry will involve the chaplain in many novel problems; he must be pliable. The only constant rule is the welfare of the patient.

5. Pastoral Listening

a. The chaplain must learn to listen. If the chaplain is to be helpful he must know what is bothering the patient and just where the patient is in his thinking. As a commander must make an estimate of the situation before he decides on a course of action, so must the chaplain make his own estimate of the situation by listening to the patient state his view of the problem. Listening is not easy for a man who has been trained to talk. But since listening is necessary, the chaplain must learn how to do it. One way in which we can demonstrate concern for another is to listen to him. Most of the time we listen only because we are waiting for a chance to talk. Listening so as to show the patient a real concern for him is much more demanding than mere social listening. Pastoral listening is listening that is permissive, focused, accepting, and understanding.

b. Pastoral listening is permissive. It is permissive in that it allows the patient a full opportunity to express his present situation in his own way. For the chaplain to make an estimate of the situation, he must find out what the situation is. The patient must be free to express his own view of his problem. The chaplain must be extremely careful not to tell the patient in words, gestures, or facial expression that there are some things the patient must not talk about. Permissive listening does not mean approving what is heard. Permissive listening does not involve value judgments. The chaplain will listen permissively because he knows he can't help if he refuses the patient the right to state his own case.

c. Pastoral listening is "focused" listening. The chaplain focuses on the patient's feelings about himself and his problems. To focus in such a way the chaplain must be concerned about the person he is presently dealing with. An interest in what the person says about others who are not present must be held back. The important person for the chaplain is the person in front of him. Focused listening is listening which concentrates on what the patient says about himself and his feelings. Focused listening keeps the emphasis on the person actually conversing with the chaplain. The chaplain often identifies himself so closely with the patient that along with the patient the chaplain finds himself growing indignant about others: a wife, the first sergeant, or someone else outside the present scene. If his interest shifts to others not present, the chaplain will become less helpful to the person in front of him. The chaplain should concentrate on the person he is visiting. By such concentration the patient will be helped to think clearly about his own feelings and to find the power to handle them more constructively by himself.

In focused listening the chaplain's responses to what the patient says will direct attention to the patient. The responses may be verbal or nonverbal. The chaplain may say, for instance, "Tell me more about how this bothers you." Or he may simply grunt, say "yes," or merely nod. If these responses are made by the chaplain while the patient is talking about his own feelings, then the patient will soon realize that he can say anything he wants to about himself and his own feelings. Thus, the patient will talk more about himself and less about what others are doing to him.

d. Pastoral listening is also accepting. The chaplain listens permissively; he focuses on the person in front of him; and he demonstrates his desire to help by accepting the patient as a person in trouble and worthy of help. The chaplain believes that the patient wants help. The chaplain assumes that the patient wants to find a way to clear up the muddled pattern of thought that has created his problem. Even if the patient has obviously done wrong, the chaplain operates on the assumption that the troubled person wants to do better. The patient will not be helped by judgmental phrases uttered by the chaplain. To pronounce judgment on a man who is suffering because of his mistakes, whether the sufferer sees them as mistakes or not, is to kick a man while he is down. No chaplain wants to destroy a patient's desire to learn to think and to do better. The patient, if he is to be helped, must know that the chaplain cares. The chaplain does not, of course, accept a pattern of wrongdoing as right. He does not accept a person as fixed at that person's lowest level of per-

formance. The chaplain, by his religion, is committed to the belief that men can change for the better. He knows that an infant must crawl before he can walk. He knows that he will not help the infant to walk by sitting in judgment upon him because he has only been able to crawl thus far. The way the chaplain listens to the patient will show the patient whether or not he is being accepted or rejected. The chaplain will be able to help only if the patient sees him as one who cares and wants to help. Listening, to be beneficial, must show that the patient is accepted by the listener.

e. Pastoral listening is listening with understanding. The chaplain must understand the facts as the patient sees them, and he must understand how the patient would naturally react to such facts. The chaplain must understand the intellectual content of what he is told. He must also understand the emotional content. The chaplain must recognize what the patient believes has happened to him. The chaplain must also recognize how the patient would react in such a situation. Merely sitting in the room and not interrupting the patient while he talks is not enough. The chaplain should show by his comments and his questions that he understands the significance of what the patient is telling him. If the chaplain shows that he is able to understand the patient's feelings in the situation, a helpful relationship with the patient can be developed. If the chaplain is permissive, focuses on the patient, and accepts the patient as a person in trouble, but does not show understanding, then the patient might just as well tell his troubles to the ceiling.

f. Pastoral listening is permissive, focused, accepting, and understanding. It is not merely social listening. Pastoral listening is skilled listening done by a professionally-trained person. The ability to listen in such a way can be learned. Any military chaplain can learn to listen effectively if he is convinced that it is important. Listening is as vital to hospital work as it is to formal counseling. A chaplain cannot help a patient without knowledge of the patient's situation. This knowledge can be gained mainly by disciplined, pastoral listening.

A useful aid in developing the skill of pastoral listening is the verbatim report. A verbatim report is the written reconstruction of a pastoral call. A sample verbatim report will be found in the appendix of this pamphlet. If a hospital chaplain will attempt to write a full report of at least three calls each week, he will soon be amazed by how much it is possible to remember. By reporting his calls in writing, the chaplain can find out whether or not he is really listening to the patients he visits. Such a practice will

develop his powers of concentration and make him an effective pastoral listener.

6. Reassurance

a. Definition. Reassurance is effectively strengthening the patient's belief in himself and in God. Reassurance is a goal to work toward with all patients. A chaplain hopes to impart the belief that God cares. Every chaplain wants the patient to experience a sustaining belief in God's love. He wants him to develop an ability to trust his nurse and his doctor, and to feel that no matter what happens God can provide the resources for dealing with it. The feeling of assurance here is not limited by whether or not the patient finds relief from pain or is restored to his former level of function. Yet it is a feeling of hopefulness and not simply a matter of giving up. The assurance sought here provides a spirit of trustfulness that cooperates with the healing forces of life. The doctor knows that an attitude of quiet assurance on the part of the patient adds to the value of whatever therapeutic forces are being utilized. Healing is faster where the patient is free from unnecessary anxiety. But assurance is more than the patient's belief that he will get well. It is the belief that even if physical health is not restored there is nothing to worry about. Such an assurance is not easily developed. To help the patient attain such an assurance, the chaplain must experience it himself. An anxious, frightened, doubting chaplain can actually harm the patient. But it must be emphasized that the assurance the chaplain needs cannot be feigned. Assurance is not whistling in the dark. It is not ignoring the reality of pain and suffering. Assurance gives the ability to face the harshest facts with courage and dignity. Such assurance is not imparted by bluff, hearty conversation, by funny jokes, or by back slapping.

b. Discussion. Assurance is caught and not taught. The patient is rarely won to a new way of thought by a logical, orderly, presentation of ideas. Certainly, the patient does not learn to find assurance by argument. To argue with a person only insures that the person is more set in his ways than he was before the argument. It is when the chaplain feels his own structure of thought is challenged that he feels the need to become aggressive in argumentation. If the chaplain is not secure in his own beliefs, he will be overly anxious to put forth his case. If the chaplain has thought through, in his own life, his attitudes towards suffering, and towards God's part in it, he will be able to absorb all sorts of questions. If he is not sure within himself, the chaplain will be inclined to talk too much.

A patient is not going to be helped by overassurance either. If the chaplain feels continually inclined to overassure, he should examine his own motives. If the chaplain indulges in continual attempts at overassurance, it may be that he himself is insecure. It may be that he is unable to let the patient deal with doubts and questions because doubts and questions are so strong within the chaplain's own mind. Assurance is infectious. If the chaplain feels assured within himself and knows that even if physical health is not achieved for the patient, God is still in charge, his feeling will ordinarily get over to the patient.

Assurance is imparted by the use of the approaches indicated in the section on Pastoral Listening. It is imparted when a chaplain is permissive, when he focuses his attention upon the patient's feelings, when he accepts the patient where he is, and when he conveys an understanding of the patient's deeper feelings. These attitudes are useful in describing pastoral listening, but they do not belong solely to the technique of listening.

When the chaplain is permissive he indicates that he is not threatened by what the patient chooses to talk about. By his permissiveness the chaplain says to the patient, "Whatever seems to be bothering you, I am willing to hear what you have to say." If the chaplain indicates, verbally or nonverbally, that the patient is not to express doubts about God's love, it is going to be most difficult for that chaplain to work helpfully with the patient. If the chaplain and the patient are to understand clearly what the situation is in the patient's thinking, the patient is going to have to be allowed to talk as he chooses, about whatever subject he selects. To get an estimate of the situation, the situation must be known. In hospital work the situation is going to be known only as the patient is allowed to express it.

As the patient is allowed to talk about subjects of his own choosing, and express whatever views he wishes, the responses of the chaplain should center on the patient's feelings. Whether the chaplain nods his head, reflects the patient's last comment, or intersperses a mere grunt, he will do so to indicate interest in what the patient is feeling. The chaplain will strive not to let his own interests intrude upon the conversation. He will concentrate upon what the patient is saying about the patient's attitudes. The concentration required of the chaplain demands that he utilize his professional training to its fullest. Such concentration is not easily achieved.

The chaplain, if he is to reassure his patient, must also demonstrate acceptance of the patient as a person. If the patient says, "How can a good God let me suffer like this?", the chaplain will

simply accept it as a normal outcry in a time of stress. If the patient attacks beliefs which are at the center of the chaplain's faith, the chaplain will still accept the patient as a person worthy of help. Acceptance does not indicate approbation. Acceptance is not saying in effect, "I agree with you." It is simply saying, "All right, that's how it is with you." Since the patient is dealing with problems of loneliness, isolation, and rejection anyway, if the chaplain rejects him it will take away the opportunity for imparting the help that patient needs. The chaplain will find that the acceptance of the patient as a person will help that patient to find a new assurance.

The chaplain can also help impart assurance to a patient by demonstrating the fact that he understands him. It is one thing to say, "I agree with what you say," and quite another to say, "I understand how you feel." If the patient finds that the chaplain can understand the outcries of a man in doubt, can accept them, and not be threatened by them, the patient's trust in that chaplain will grow. When the chaplain responds with understanding compassion to a person in need, that person tends to grow toward the acceptance of the fact that God cares. It is understanding of this nature that enables rapport to grow to a point at which the chaplain can offer more pointed help. If the chaplain cannot understand the patient and his questions, the patient will soon know this. If the patient does not feel understood, he will not feel like continuing the contacts. If, however, the patient does feel understood, then the stage is set for a continued, helpful relationship.

What has been said about helping the patient to gain assurance holds true unless the patient is a victim of emotional illness. A patient who is pathologically depressed will not respond. If the person is emotionally disturbed and it becomes obvious that he does not react normally, and he is not being seen by a psychiatrist, the chaplain should confer with the doctor in charge of the case. The chaplain should then simply state the facts as he sees them and recognize the fact that the doctor in charge of the case has the responsibility about whether or not to refer. If referral is made to a psychiatrist, then the chaplain might well see the psychiatrist concerned and get his views on the case. The psychiatrist may wish the chaplain to continue seeing the patient. Often, at any rate, he will not object.

It is important for the patient to be reassured. For this reassurance to help, however, it must be something experienced by the patient. Nothing can take the place of the patient's own sustained faith. Such a faith is imparted by contagion and not by self-conscious instruction.

7. Ventilation

"Ventilation," according to Horace and Ava English, is "the activity of talking freely about a problem, expressing and exposing one's emotions with respect to it."[1] The term "ventilation" is used in this pamphlet because it is broader than the term "catharsis" which has a specific psychoanalytic meaning. When it is said that ventilation refers to talking about a problem and expressing emotions about it, this includes talking about persons and expressing emotions about them. Ventilation refers to talking about interpersonal problems and feelings connected with them. Any chaplain who visits in a hospital will find patients suffering not only from the pain of their illness, but also from their feelings about persons. These persons may include a husband or wife, a mother or father, a son or daughter, a friend, a first sergeant, a company commander, a doctor, or anyone with whom they are concerned. Problems involved in thinking about God will also be included among those problems about which patients feel a need to talk.

There can be a great value in allowing a patient to ventilate his feelings about others. The chaplain need not be afraid that he will encourage the person in a negative way of thought. If a patient wishes to talk about how angry he is toward a doctor who has prescribed a certain unpleasant treatment, the chaplain should not leap to the defense of the doctor. If he tries to stop the patient, this will confirm the patient's thought that he is the victim of a conspiracy against him. Most of the time, simply allowing the patient to state his negative feelings about another will lead him to a better understanding of the other party. The chaplain will note that the patient will stop expressing negative thoughts and start examining his own involvement; for instance, if the patient is allowed to continue to talk, he may begin to see that the doctor is working to help him. Of course, there may be times in which the patient will be right in his negative reaction to the doctor. When the patient is correct in his judgment, the chaplain will not help by confirming what the patient said. If the chaplain is convinced that something has gone wrong, he should go and talk to the doctor about it. Ordinarily, the doctor will be glad to get the information. One who works with sick people all the time is aware of the possibility of being misunderstood. The doctor is usually not offended by what the patient has said, rather he considers the information important in his further treatment of the patient. The chaplain assumes members of the medical profession are interested in bettering their relationship with their patients, and that they see their relationship with their patients as a therapeutic help.

[1] *Comprehensive Dictionary of Psychological & Psychoanalytical Terms*, Horace B. English & Ava Champney English, Longmans, Green & Co., 1958.

The chaplain should not indicate alarm in any way when the patient begins expressing anger toward a member of the patient's family. He will understand that in all men there are ambivalent feelings. By ambivalent, it is meant that the ordinary person at times is angry towards those whom he loves. The chaplain will not see anger as a denial of love; he will see it as the normal expression of a personality in all of its complexity. The chaplain will see that the demands of reality cause hostile feelings in the most religious, as well as in those not at all interested in religion. The chaplain will not confirm what the patient says; he will not approve it; nor will he show disapproval. It is difficult for us to see that the best thing to do with a person in trouble is to allow him to express his honest feelings. As a patient expresses his feelings he sees what they mean. He corrects them as he begins to see how he is involved in the problem, and he arrives at a more helpful view of things as they relate to him.

While ventilation is ordinarily helpful, there is something else to consider. One theory of personality has been termed the "reservior" theory. This means it is conceived that persons have in them a certain store of hostile feelings. According to the "reservoir" theory, as hostility is expressed, the stockage of hostility is depleted. After the patient has expressed his feelings of hostility, then he is no longer under tension. Now he is better able to make an honest judgment about his life situation. However, there is another personality theory that varies from the "reservoir" theory; this is a theory that has to do with training by conditioning. If a person is encouraged in one course of action, it becomes easier for him to follow the same course of action the next time. Much learning is based on this theory of repetition. As a person performs physical actions over and over, whether it be firing on the range or swinging on a high trapeze, he becomes more skillful. This theory of training is carried over by some into the arena of the emotions. Thus, it is observed when a person learns to express his anger it becomes easier for him to express anger. So, if a person is encouraged to ventilate, the danger arises that he may learn to express the same feelings over and over. As these same feelings are expressed again they become more intense. It is true in a small number of cases that this happens. The chaplain must be aware of the danger. He must be sensitive to each patient as an individual.

If the chaplain becomes convinced that the patient is no longer truly discharging negative emotions, but is rather storing them up and adding to their intensity, he will find ways to discourage such activity. How is the chaplain to discourage the compulsive repeti-

tion of negative feelings? The chaplain will discourage such repetition indirectly. He will not simply state that he wants to hear no more of that particular subject, rather he will point out to the patient the fact that he has begun to repeat, and that it hasn't seemed to help him. In other words, the chaplain will confront the patient with what has been said in such a way that the import of his action is made quite obvious to him. When the patient sees what he has been doing, he may become aware of the danger to which he is exposing himself. If so, the patient will correct this habit and will begin to talk more positively. If the patient is not able to make this correction himself after he is confronted with what he has been doing, the chaplain had better leave him to the doctor. If the patient is able to make the correction, he will do so. If he is not, there is an indication that he may be mentally ill and no amount of exhortation or tearful pleading will dissuade him. When the chaplain has reached such an impasse, it may be that he will want to suspend his visits to that patient, or, if he continues to visit, the chaplain will find ways to direct the content of the conversation into more hopeful areas. What is said here about the danger of ventilation does not negate the value of ventilation in the great majority of cases. As the chaplain continues in his hospital work, he will become better able to cope with the danger, and better able to make good use of ventilation.

The chaplain will find it helpful to allow the patients he visits to express their feelings. This is true even if these feelings appear to be very hostile ones expressed in a negative fashion against hospital personnel. The chaplain is not disloyal to other personnel in the hospital when he allows the patient to express his anger or other negative feelings. An expression of these feelings is often the best way to handle them. As the tension level lessens, the patient will ordinarily make his own correction and see things with a better humor. However, if he is not allowed to talk about such matters, he will hold his feelings within and they will influence the course of treatment negatively. In spite of the chaplain's natural desire to fly to the aid of those with whom he works, he will learn to control himself in a hospital situation. In the long run he will allow the patient to express negative feelings, as it is by far the best way to handle them. The chaplain should also be sensitive to the few cases in which expression of negative feeling only makes it easier to continue in a negative rut. In these cases where ventilation does not help, the chaplain will confer with the doctor and will decide carefully whether or not he is to continue seeing the patient. The rule is to allow the patient to express any feelings that he has. The exception to the rule is where the patient seems to dig a deeper conversational rut.

Again, it may be seen that the attitudes included in the section on pastoral listening apply here. Ventilation is encouraged by attitudes of permissiveness, acceptance, and understanding. Focusing on the feelings of the patient will also help him to ventilate. The skilled chaplain will make much use of the method of ventilation as he does his work in the hospital.

8. Summary

Every chaplain at one time or another has the duty of visiting in the hospital. There are certain principles which are helpful for all chaplains, whether they are assigned to a hospital or simply visiting within a hospital. If certain commonsense guidelines are observed, the chaplain will build a good relationship with the patients and, therefore, will be able to be more helpful.

The specific ecclesiastical rites of various churches are not referred to here. The chaplain should know the requirements of his own church. He should also know when to refer to a clergyman of another faith. However, in most hospital visiting, it is at first important to relate well to the patient. It is important that the medical maxim "do no harm" be observed. The forces of healing are on the side of the chaplain and the doctor if both can avoid doing anything to interfere with such forces. Aside from the simple rules which must be consciously observed at first, and which later become a natural part of the chaplain in his work, other matters have been discussed in this section. The techniques of pastoral listening have been outlined. An attempt has been made to describe what pastoral listening is and how it works. It might be indicated that pastoral listening is not the only stock and trade of the hospital chaplain, but it is a very important part of his work.

This section has also dealt with the matter of reassurance. Certainly, it is important that the patient gain an assurance about himself and about his life that enables him to trust the doctors and nurses with whom he is working. It is more important that this assurance extend to his views about the purpose and meaning of life so that he can see meaning, even if his illness should end in death or the loss of some physical capacity. It has been observed that assurance is not imparted by argumentation or by verbal reassurance, but rather, indirectly, through the chaplain's basic faith.

Ventilation has also been pointed out to be an important means of helping a patient discharge negative emotions.

The rules, methods, techniques, and attitudes discussed in the pamphlet are helpful in all cases where the patient is not emo-

tionally ill. The approaches will also be helpful with many who are emotionally disturbed, but in these cases it is well for the chaplain to confer with the psychiatrist who is in charge of the treatment.

SECTION III

THE UNIT CHAPLAIN AND THE HOSPITAL

9. Introduction

The unit chaplain has the duty of visiting the sick of his organization. In his responsibility toward the sick he carries on in the tradition of the clergy throughout the ages.

It is not enough for effective pastoral care simply to have a chaplain assigned within the hospital itself. The patient still needs contact with his own unit, and the chaplain of that unit is best suited to maintain such contact. To be used to best advantage in his work with the ill the chaplain must work systematically. Adequate coverage for his organization requires planning. It is only through visiting routinely in the hospital that the chaplain can be certain of being called for in times of deepest need. To serve effectively in moments of greater stress, the chaplain should establish a background of continual, routine calling to demonstrate his interest in the welfare of his people.

10. Planning for Hospital Coverage

a. Notification of Chaplain. The unit chaplain should develop a system of reports to his office so that he can be sure of being informed as soon as those within his pastoral responsibility are hospitalized. Such persons should be visited as soon as possible. Contacts made early in hospitalization make later work more effective.

It is often not enough to rely upon admission sheets as circulated from the hospital itself, as these are sometimes delayed in their passage through message center. A system must be devised within the unit so that the chaplain may be available with minimum delay. In some situations the medical section within the unit can keep the information up to date for the chaplain. Another approach is, with the cooperaiton of the commander, to require that each company headquarters notify the chaplain directly, by telephone if desired, when a member of the unit is hospitalized. Since it is often the battalion adjutant who has best access to information about dependents and their hospitalization, he should be included in the plan. Where the chaplain is operating above battalion

level, reports should be consolidated at battalion and then forwarded to the chaplain's office.

In devising a system of reporting on hospitalizations within a command, the chaplain should consult with others on the commander's staff. Developing the system in coordination with the staff has the advantage of insuring the cooperation of the commander and making certain that a practical system is decided upon. When a man has invested some of his own thought in a program, he tends to remain interested in it.

b. The Unit Chaplain and the Hospital Staff. To make his visits most helpful the unit chaplain should build a good relationship with key hospital personnel. He should know the hospital chaplain, those who work at the information desk, and the personnel assigned to Admissions and Dispositions. He should also know as many of the doctors and nurses as is possible.

The hospital chaplain should be contacted on each visit to the hospital when it is at all practical. From him the unit chaplain can determine the specific needs his people have developed. In emergencies, the hospital chaplain will have knowledge it would take the unit chaplain some time to get elsewhere, and, often, time is of the essence. On the other hand, the unit chaplain can provide the hospital chaplain with necessary information about the patients and their problems outside of the hospital. A mutual relationship helpful to both chaplains in their cooperative ministry to the patients can be developed.

The unit chaplain will find it valuable to build a relationship with the personnel at the information desk. In most hospitals it is through this office that emergency calls are made to unit chaplains during the day, and duty chaplains in the late evening and early morning hours. If the personnel there know the unit chaplain and how to reach him at his work or in his quarters, they can get important information to him quickly. A good relationship with the chaplain will make them want to seek him when he is needed. The chaplain should cooperate with the information section by notifying the person on duty when he arrives at the hospital and when he leaves it. Thus, someone at the desk will know when the chaplain is in the hospital building and how he can be reached while there. Such close coordination will insure that hospital coverage is immediate. Again, time is often of vital importance within the hospital. The chaplain will find his time well used in demonstrating his interest in those people with whom he works. It is natural for people to respond more warmly when they know the person with whom they are working.

Also of importance to the chaplain in his work is the "Admissions and Dispositions," or "A and D," section. During duty hours, emergency information is often channeled through this office. Those at work there know the administrative arrangements which must be made during emergencies, and, they may be able to advise the chaplain as to specific needs. If the unit chaplain is known to personnel in the "A and D" section, they will tend to contact him directly when he is needed and save time. Such a direct contact should only be made to meet an emergency situation and not to avoid normal channels. When corners have been cut, the hospital chaplain should be notified as soon as possible both as a matter of courtesy, and so that he can be of service.

It is wise for the unit chaplain to know as many of the doctors and nurses in the hospital as possible. He should confer with the ward nurse about patients from his own organization. He should inform her of his presence in the ward on each visit, and should also find time to talk to her at some length. Often nurses are quicker to discern emotional needs on the part of the patients than are the doctors whose contacts may not always be so frequent.

In some instances, the chaplain will want to see the doctor attending patients from the chaplain's unit. It is best to make an appointment so that there is no unnecessary loss of time. The doctor may feel free to advise the chaplain as to some of the problems the patient is facing, so that the chaplain may be of more assistance. At other times, the chaplain will have information important to the doctor in his work. In all cases, care must be taken to make certain that professional confidences are not violated, yet some information can be passed on quite ethically. In certain hospitals it may be better for the unit chaplain to work through the hospital chaplain in getting information to and from the doctors, or at least, in arranging the appointment. The hospital chaplain will already have a working relationship with the medical personnel. Certainly, it is important that those who are in contact with the patients be aware of what each one is doing and thinking if the patient is to receive the care he needs.

11. The Duty Chaplain

Most installations provide a roster for chaplain coverage of the hospital at night, even when there are chaplains assigned to the hospital. Such rosters provide for Protestant, Roman Catholic, and Jewish coverage. A chaplain serving as "duty" chaplain should personally take care of emergencies after duty hours or when the unit chaplain is not available for other reasons, but he should inform the unit chaplain concerned as soon as he can. Unit chaplains

should cooperate by keeping themselves available so that they can be reached easily when needed. If it is absolutely necessary for them to be away from a telephone, word should be left as to when they will return. Duty chaplains at best can offer only emergency coverage; anything of a continuing nature must be performed by the unit chaplain.

12. Summary

Effective hospital coverage must be systematic. The command will assist the unit chaplain in developing an adequate plan for such coverage. It will insure that others within the unit know what the chaplain plans to do, so that they can assist him in his task.

The unit chaplain will find it helpful to make personal contacts with key personnel in the hospital. Good personal relationships with hospital personnel will save wasted steps and valuable time, so important for effective work with the sick. The chaplain will find that cooperation with doctors and nurses, as well as with the hospital chaplain, can strengthen his work within the hospital. Both the medical profession and the ministry are interested in the total welfare of the patient, so there is nothing to prevent their working well together.

With careful, systematic planning, the unit chaplain will be better able to carry out effectively the traditional responsibility of the clergy to visit the sick.

SECTION IV
SOME GENERAL CONSIDERATIONS

13. What is Health?

It is often assumed that health is a state of being that is easily defined. Such an assumption is false. Some may consider a person healthy who is able to continue to function adequately at his work and in his social relationships. But how is one to define "adequately"? It is assumed by many that physical health may be attained although a person has lost an arm or a leg or some other part of the body. It is possible to compensate for such a loss if the patient's attitude is right. If the body is able to organize itself to such an extent that it can go on with the process of living, it is felt by some that the person has attained health. There are others, of course, who would demand a definition of health as the ability to function at an optimal level, at the highest peak of performance. If such a view is taken, then few will ever be considered healthy.

With the recent reemphasis on the oneness of body and mind, it becomes clear that true health is not attained without mental health. An attempt to define mental health is an even more difficult task. When we talk about mental health we include both the intellectual and the emotional side of man. If a person's attitudes towards others, towards himself, and towards the demands of his life are such that he is able to function with some enjoyment, it may be said that he has mental health. Remember that the emotions affect the physical well-being and vice versa. Physical ailments and difficulties can create emotional problems. However, if a person is in charge of his life emotionally, he may be able to accomplish much in spite of a low state of physical well-being. In the writings of a modern psychiatrist, Doctor Nathan W. Ackerman, the following definition of mental health is given:

> Mental health is not a static quality in the private possession of anyone. It is not self-sustaining. It can be maintained only by continuous exertion and with the emotional togetherness and support of others. Ideally, it is the result of balanced and creative personal functioning that fulfills the best of man in social relations. It is the outcome of a capacity for optimal fulfillment of the individual's potential for group living. It means successful and satisfying performance. It alludes in a general sense to such attributes as matur-

ity, stability, realism, altruism, a sense of social responsibility, effective integration in work and in human relations. It implies confidence and courage in facing new experience. It implies a value system in which the individual's welfare is joined to that of others; in other words, it implies a concern for the common good. As has been indicated, mental health is a quality of living, a process. It is achieved by a continuing struggle for better personal adaptation. It cannot be maintained in isolation, for satisfying emotional union with others is necessary for its preservation. It is concerned not only with inner harmony but also with optimal relatedness of person, family, and society. It implies the capacity to grow, to learn, to live fully, to love, and to share with others the adventure of life.[2]

It is obvious that religious understandings of good emotional health have much in common with Doctor Ackerman's view.

14. What is Illness?

Certainly, illness is a departure from the healthy state. Illness may not be recognized until there is the breakdown of proper functioning. On the other hand, it may be recognized when the organism has made the turn away from health and before deterioration has become evident. Most therapeutic gains are made when detection of illness occurs early in its course.

15. Some Common Problems

The hospital chaplain should work with all types of patients. It is a mistaken view of his function to feel that he must spend his time only with the emotionally disturbed, the group we sometimes refer to as the "mentally ill." The normal person in a hospital is under stress, also, and can often be helped by the approaches and attitudes of pastoral care.

Simply being hospitalized tends to create new problems for the patient. It is false to assume that most patients in the hospital have no problems. Being in the hospital is a problem. There are certain areas of difficulty that seem to be experienced by most hospital patients. These include:

a. Rejection. Consciously or unconsciously the patient interprets his illness as "rejection." He feels that he has been discarded by life itself. He may experience this as feeling cast off by God. If the patient does not interpret his feeling of rejection as rejection by God, he may interpret it as rejection by his fellow men. With such feelings of rejection, it is a fact that anger is a prevailing emotion among the hospitalized. There is anger towards the visitor for the simple reason that the visitor is well enough to be up. The simple fact that the hospital chaplain is standing up is a

[2] *The Psychodynamics of Family Life,* Nathan W. Ackerman, M.D., Basic Books, Inc., 1958, pp 7–8.

threat to the patient who cannot do so. The sense of rejection is one of the common experiences of all hospital patients.

b. Isolation. Another common problem of the hospitalized is the loneliness that comes from being isolated. A patient in a hospital is cut off from family and friends. Except for brief visits fitted into the schedule of the hospital, the patient cannot see those whom he loves or to whose presence he has become accustomed. The patient is also isolated from physical surroundings to which he has been accustomed. In the case of contagious diseases, this isolation is even more complete. It is also quite complete with those who must remain in bed and are not allowed to get up at all. The sense of isolation adds to the anger that tends to permeate the hospitalized patient's attitudes. Isolation for the emotionally mature, who are able to look at life philosophically, may not be much of a problem. But to the majority of people it is a problem. Man is at least a social being. He exists at his peak in his social relationships. Anything which interferes with his sense of oneness with others, creates a problem in his attitudes. Hospital patients as a group share the problem of isolation. Some patients experience it at different intensities than others, but it is common to all.

c. Regression. Regression is moving back emotionally in the direction of infancy. Hospital patients are forced to regress. Part of what is meant by this is that hospital patients are not able to take care of themselves as completely as they once were. There are certain things the patient cannot do for himself, even if he is ambulatory. He cannot go back to his unit and take care of his car, for example. He must rely on his friends and on his organization to take care of his physical possessions which are in the unit area. The hospitalized patient must rely on others to take care of his pay difficulties, to bring him clean clothing if he is to go on pass from the hospital, and, in many ways, to take care of things he ordinarily would handle himself. This regression becomes more pronounced where the patient is sicker. If he is in an isolation ward or if he is unable to get out of his bed, then there is even more that must be done for him. He must be helped with basic matters of personal sanitation. He must be bathed, a bedpan must be brought to him, he must be watched as an infant. The normal adult resents the necessity of regression; he wants to stand on his own feet. When he cannot, he is liable to feel angry toward life itself and toward any person who comes in contact with him. The problems caused by regression may be unconscious, but the sensitive and trained hospital chaplain will note them and accept them as part of the general problems of the hospitalized person.

16. Attitudes That Strengthen

If the patient has a healthy view of life's meaning, he will handle his period of hospitalization well despite his problems. If the patient sees little meaning in life, his hospitalization will be a destructive experience for him. The hospital chaplain has a task to perform at this point. The chaplain, as a representative of religion, believes that a large portion of life's meaning is found in the experience of love. This love must be seen in the lives of persons and not merely in philosophical statements. If the chaplain believes that the deeper meanings of life are attained in a background of love, and that love itself is a justification for living, he can often transmit this attitude to many of the patients he serves.

The chaplain may not feel that he has the final answer to the problem of suffering, and he may not feel that, theologically, the patient's problems can be understood. In spite of this, the religious person believes there is meaning. Such an attitude is transmissible.

The chaplain understands that the patient is feeling lonely and rejected, and is probably irritated by the necessary regression caused by his hospital experience. Such feelings are often expressed as hostility. The chaplain should not interpret the anger and hostility expressed by the patient as a threat to him. He is not disturbed because the hospitalized person does not experience life as all sweetness and light. The fact that the chaplain is not thrown by negative feelings is, in itself, a source of strength for the pateint.

The chaplain, as a representative of God, is important to the patient's emotional health. There is no one else on the hospital staff who, by his very role, stands for meaning in life. The chaplain is the only one in the hospital who, by his profession, represents God. Some patients, in the past, have seen clergymen as threatening, punitive, and destructive. The hospital chaplain's attitude of compassion and of accepting love can help overcome these negative feelings. Where patients have experienced the Church as a positive factor in life, the chaplain is immediately useful. With the patient who begins with a negative reaction to the Church, the chaplain has to work to overcome past impressions. If he is successful in helping the patient exchange negative responses to the Church for positive responses, he has brought the patient a valuable gift. As most patients have problems when they are hospitalized, so most patients may be helped by a capable hospital chaplain. The importance of the chaplain's work within the hospital becomes quite evident when the general problems of hospitalization are observed.

17. Summary

Hospitalized patients tend to have certain common problems which result from the feelings of rejection and isolation which accompany hospitalization. There is an added common problem in the natural regressions caused by the fact of hospitalization. "Isolation," "rejection," and "regression" are emotional problems which can be well handled by a hospital chaplain.

Another common problem is that caused by the patient's attitude toward life. If he has a secure feeling about life, if he trusts God, he can face many difficulties adequately. If he already feels defeated by life, his illness is one more evidence of that defeat. The chaplain, with his demonstrated concern for the patient, with his own faith in God, and with his willingness to accept the patient as he is, is in a unique position in the hospital. No one else on the hospital staff can take the chaplain's place.

If the chaplain is aware of the problems of the hospitalized person, he is already well prepared to help him deal with them. The chaplain can help the patient by accepting him as worthy of help and by compensating for a patient's loneliness by recurrent visits. The chaplain can deal with the problem of regression by helping the patient accept and understand his feelings. The chaplain should be enough of an authority figure to support the patient through this time of regression without encouraging unhealthy dependency. The chaplain should remember that the ultimate aim is to restore the person to the control of his own life and not to keep him dependent upon others. To be of greatest value in his hospital work, the chaplain should have some positive convictions as to the ultimate meaning of life.

SECTION V
THE MEDICAL WARD

18. Special Considerations

Since the problems of the patients on general medical wards actually tend to run the gamut of hospital experiences, this section will contain material which will be helpful throughout the entire hospital, as well as within the medical ward itself.

The hospital chaplain in his work on the wards should not try to create problems, but he should be aware of the possibility of the existence of problems with his patients. The best rule for him is to be prepared for anything and to be shocked at nothing. Although there are persons who are so well adjusted that they have few problems, the chaplain should be suspicious of the patient who denies too emphatically the existence of any need for help, as he may be evading the issue. Clinical studies have shown that those who deny the existence of any fears connected with their illness, or expected surgical procedure, may have greater problems than those who admit a certain amount of fear. These matters will become obvious through experience. However, it may be of help to attempt to list certain problems which do appear to be fairly common.

There are many and varied problems which the chaplain will find involving patients in the general medical ward. His task is to discover the immediate problem that is troubling the patient and help him work through it. In any ward the trouble which most concerns the patient may be something outside of the hospital. For the first time he is left alone to think at length about many problems. It may be that his illness doesn't concern him as much as his marital problem. It may be that his thoughts are troubled by problems involving his children. In these cases, where the problems are only indirectly related to the illness, the chaplain can best help by performing as a qualified pastoral listener as described in paragraph 5.

If the patient is suffering from an acute illness, or is in an acute phase of an illness, he may have so much pain that all of his thoughts are centered on his physical condition. He may not even be able to talk. If the patient is suffering from such pain that he cannot talk and does not want to talk, the chaplain should not

assume that he is unwanted. Many times a sensitive hospital chaplain is able to help by simply coming into the room, identifying himself, and saying, "Please don't feel it necessary for you to talk at all—I'd like to just sit with you for a moment." After this, the chaplain remains seated quietly with the patient, responding to his requests, or answering any questions, but not striving to make talk. One of the main difficulties of clergymen is their feeling that people must talk, or hear someone talk, if they are to be helped. Such is not the case. What is important is that concern and compassion be demonstrated, and these may often be demonstrated best by remaining silent, and by indicating enough concern to take time out from a busy routine simply to sit quietly for a few minutes with the patient. It is surprising how much help some patients gain from such an action on the part of a chaplain. Later, when the patient has better control of himself, he will be more able to discuss other problems with the chaplain because of such demonstrated concern during the quiet moments. Sometimes, prayer will be called for in these moments of intense pain. However, sustained concentration is impossible on the part of a person in agony. Therefore, prayers, to be helpful, should be short. Such prayers should recognize the pain that the patient is in and the importance of this pain to him. After recognizing the pain, however, the prayer should contain a more reassuring closing sentence, one which reminds the patient that his immediate pain is not all there is to life.

The patient in the medical ward may have a disease of a chronic nature. In this case, the pain and fear, although present, may not be intense. Yet the chaplain should not assume all is well. Some people will respond with greater fear to a mild disorder than others will to a serious illness. The patient's reaction to his immediate problem depends mainly on his development as a person. If as a child he has undergone many experiences of separation and rejection, any illness will tend to reactivate those early fears and make them more intense than the immediate situation calls for. The point here is that it is never a good thing to assume that there are no problems. The chaplain who listens carefully will find that the patient will tend to bring up his problems after a good relationship has developed.

There are cases in which deeply-threatening problems will be brought out by a patient on a first contact. Such a need to ventilate occurs when the patient is under a great deal of tension and has been for some time, or when he is unable to tolerate even the slightest little tension. If the patient has been under tension and a considerate, compassionate person appears on the scene, he will tend to pour out his life's story in the first interview. It is im-

portant in such cases for the chaplain to listen. However, he will be wise if he does not apply "techniques" to try to capitalize on the moment of turmoil. He should let the patient discuss as much as he wants to in the time available, but not deliberately encourage a prolonged continuation of such an outpouring, as this may cause problems later. Often the chaplain will be led to think that since his first interview was such a productive one, the second contact will be even more so. The chaplain may, in fact, get little at all from the patient on the second interview. What appears to happen is that left alone the patient realizes that he has talked quite a bit to someone who actually is a stranger. His guard will tend to be up on the second interview, and the chaplain must be willing to take it easy and let the relationship develop more slowly.

In every contact there is a breakdown into sections. There is an introductory period, the body of the conversation, and a concluding period. This breakdown holds for each individual contact, each isolated interview, but also for each series of interviews. The patient needs time to develop his opinion about the chaplain. He must have time to decide whether or not he can confide in him. If for any reason, as in the case of the accumulation of tension cited above, the introductory phase is bypassed, it must be returned to. This accounts for many apparently unproductive second interviews.

While the chaplain ought to be the chaplain, and not attempt to be a doctor, he should read the literature of psychosomatic medicine. He should read it with the idea in mind of getting understanding of what he is doing and not with the idea of becoming a diagnostician. Reading in the literature of psychasomatic medicine should show the chaplain how vitally he is a part of the therapeutic team.

If the chaplain follows the techniques of pastoral listening and develops them as much as he can, his visits will become therapeutic. This does not mean that the chaplain's only value is in the realm of therapy. Nothing could be farther from the truth. The chaplain's greatest help is in the realm of religion, passing to the patients a higher hope. However, it is helpful to know that the outcome of an illness may also be influenced by the chaplain.

It may be well to know, also, that the patient's development could be hindered if the chaplain is not understanding, accepting, and compassionate. Brief visits by untrained chaplains, in which the patients are informed that their illness is probably the result of sin, can be quite destructive. The chaplain as a clergyman, whatever his theology, must remember that he is not sent into the world to destroy. This does not mean that he has to approve of

all that the patient has done. It simply means that he must accept the patient as a suffering human being needing compassion at the moment, without regard to what he may need in the future in the way of discipline. The moment of intense personal suffering is not the time for the chaplain to force his personal ideas upon the patient. He may, at this time, establish such a warm relationship that later the patient tends to accept what the chaplain believes, but this is quite another matter. It is surprising here again how valuable the medical maxim "do no harm" is to the chaplain. For if the chaplain can "do no harm" he will help create an atmosphere in which the patient can be helped. The healing powers within the patient can be released by demonstrated concern. It may be true that in the realm of psychosomatic literature the final answers are not yet clear, yet there are enough insights represented to make it worth the chaplain's time if he is to develop himself as an instrument of value in the hospital.

Someone has said, "All fear is the fear of death." It is certainly true that the fear of death is a companion of every human being. When a person is hospitalized, however slight the disorder, the fear of death becomes an active factor in his thought. It is true that this fear of death may not be expressed in so many words. It may be expressed in his feelings of loneliness, for the separation involved in death is akin to any separation. The patient is separated from his friends and from his family in a way which is in some ways like the final separation which he fears in death. The fear of death may be expressed in anger or in lack of cooperation with the hospital staff. It may be expressed as anger toward God. Very few people will actually express anger toward God directly, but such anger can be expressed toward the Church and, indeed, towards the chaplain who as a minister represents the Church. Many of the patient's negative reactions to the chaplain will be simply an expression of the fear of death. The chaplain should be alert to this fear and to the many different ways it is expressed. To help patients handle such fears, the chaplain must express in some way his faith in life. Such belief will be conveyed not by preaching but, in one way at least, by the chaplain's ability to remain undisturbed in the midst of death. The chaplain, to be helpful, must be able to handle his own death fears. As the patient begins to speak of his fear of death, or to express it in some ways, the chaplain will tend to find his own fears reactivated. The chaplain may react compulsively as a preacher and make long statements about his faith. The patient, at least in an unconscious level, will problably recognize this as lack of faith rather than as its presence. The chaplain may tend to argue with the patient's views about death and, in other ways, show that his own death fears have been

activated. If the chaplain is to help, he must be able to cope with this problem in such a way as to remain calm, not cold nor aloof, but calm in a compassionate way.

Sometimes a chaplain will find that his ministry must be carried on with the family of the patient rather than with the patient. This is less true in military installations where the family is often far away, but it nevertheless happens. The chaplain making his calls will sometimes find a patient in a coma, or that the doctor is supervising a treatment procedure, or examining the patient, and he will not have access to the patient. The chaplain, although realizing his primary duty is with the patient, will not turn aside from dealing with the hopes and fears of the family. He will not try to deal with family and patient at the same time, except in a social way. If the chaplain is to deal with the hopes and fears of the family, he should concentrate upon them. If he is going to deal with the patient's fears, pains, and problems, then he must concentrate on the patient. In some ways the fears of both may be the same, and yet there are differences. The main difference is simply that the patient is recognized to be sick and his family is supposed to be healthy. It will become obvious that different problems will be emphasized in both, and that such problems are better dealt with separately. If the chaplain is never able to find a patient alone as he makes his tour through the ward, he may, in a tactful way, ask the family to leave him with the patient for a time. If a chaplain does not feel that he can handle such a matter directly with the family, he may ask the nurse to ask the family to leave for a time, even as she would for the doctor. The chaplain must keep his contacts open with the patient. However, when the chaplain is dealing with the family, he must remember that he should focus on them. The pain that the patient is undergoing is important, certainly, but when the chaplain is talking to the patient's wife, for instance, he must think also in terms of the discomfort involved for her. It is not an easy thing to travel long distances and to put up with inadequate quarters to be with a loved one. It is not an easy thing to do away with sleep and with normal contacts while trying to be with the sick, when one is healthy. It is not disloyalty to the patient to concentrate on the problems that are very definitely created for the family. It may be that the chaplain will, in the long run, help the patient more if he allows the family to express their negative feelings freely to him. If the family finds that they can express such ideas to the chaplain, they will have no need to express them to the patient, even indirectly, but will be free to offer their full concern to him.

19. Summary

The general medical ward offers many challenges to the hospital chaplain. Often the challenges are not directly related to the serious nature of the illness. Individuals respond in different ways. The chaplain will serve best in the medical ward if he keeps open to whatever problem may be bothering the patient at the moment. The chaplain's obvious task is to help the patient with the problem that he wants help with. The professionally-trained chaplain will learn through the techniques of pastoral listening to identify the problem area. It is an exacting task to be asked to determine where the problem lies, and then to deal with it. The minister often has no indication of where the real problem is. He must be willing to be open enough to discover the area of real concern and then to deal with it. This means that the chaplain will have certain difficulties in his own thinking; he will be insecure because he is moving in the area of the unknown. If the chaplain is alert to the fact that he will probably have difficulties with his own feelings, he will not be disturbed so greatly when those problems come. Being alert to the possibility of problems enables the chaplain to prepare to meet them. The same principle here is seen in the importance of military intelligence. To known the problem is to be able to cope with it more adequately.

SECTION VI
THE SURGICAL WARD

20. Special Considerations

The military chaplain should be among the best prepared of persons to work with patients facing surgery. Irving L. Janis, in his work, *Psychological Stress,* has pointed out that major surgery activates many of the same fears which are felt in any extremely dangerous situation, such as in combat. Doctor Janis points out that the patient facing surgery must meet a combination of " . . . three major forms of imminent danger—the possibility of suffering acute pain, of undergoing serious body damage, and of dying." He goes on to say further, "Any valid generalization about the effects of one type of severe physical danger is likely to be applicable to any other crisis or disaster if it entails the same basic threats of pain, injury, and annihilation."[3] It should be seen then that the military chaplain ought to be prepared to help the surgical patient with his problems. It is apparent that in working on a surgical ward the chaplain can develop techniques and approaches which would be equally as helpful on the battlefield. It is obvious, also, that the chaplain is needed in the surgical situation, and that no one is fitted to take his place. The role of the minister is often interpreted by the patient as one connected with death and dying and the control of both. The patient's unconscious magical thinking will inevitably lead him to feel he is in the presence of an authority figure when the chaplain is present. This propensity of the patient to interpret the minister as an authority figure makes it all the more important that the chaplain receive as much training as he possibly can. The authority which he uses when he capitalizes on the patient's infantile interpretation of him must be based on reality. The chaplain must know what he is doing.

The problem of regression was discussed in an earlier section and yet, this problem has specific application to the realm of surgery. When the patient is no longer in control of his own body, when he is unable to take the measures he would ordinarily take to protect himself from pain, when indeed his very life is subject to the skill of the surgeon, he is likely to develop strong dependency

[3] *Psychological Stress,* Irving L. Janis, John Wiley & Sons, Inc., 1958, p. 10.

needs. The dependency needs of the ordinary patient facing surgery are real needs and are not to be interpreted as neurotic manifestations. The patient is indeed dependent on his surroundings and on the authority figures with whom he works and lives. He tends to look to his surgeon as a "father" figure. He will hang upon every word of the surgeon, as he once turned to his father for advice and information. Or he may rebel against the surgeon as irrationally as he did against his father. If the surgeon had the time and the psychological training, he would be able to handle the fears of most patients. However, the psychological relationship with the patient, although important, is usually not fully developed by the surgeon due to lack of time and training. The psychiatrist, in his specialized work, will not have the time to deal with each surgical patient, or indeed even with those with the most pronounced problems. The psychologist is engaged ordinarily in other fields and will not be available for this task. It appears that the chaplain trained to work within the hospital is the person most suited to help the surgical patient with his feelings. The chaplain is, also, already an authority figure, both as an officer and as a clergyman. In preparing a patient for surgery the chaplain will accept regression. In other words, he will not expect the patient to stand on his own feet psychologically and emotionally. He will allow the patient to regress and, as an authority figure, will attempt to convey to that patient a feeling of assurance. It must be stated that this feeling of assurance is not a superficial thing, nor is it superficially conveyed. The section on reassurance has dealt with this matter already in this pamphlet. The reassurance will come more from the relationship with the chaplain and the silent infectious transmittal of the chaplain's basic feeling about life to the patient. In other words, the patient will "catch" the chaplain's attitude of basic trust and hopefulness.

As the patient regresses, this means that he becomes more childlike. He moves back specifically toward his own childhood. As the patient moves back towards childhood, he reactivates childhood conflicts. If he has never felt accepted by his father or has had to undergo long periods of separation, due to divorce, or due to the physical absence of the father, as in an oversea assignment, his fears are going to be intensified. The immediate threat of surgery is certainly going to create realistic fears, but these realistic fears are going to be made more intense by fears growing out of the past.

The chaplain can help in many cases with the patient who has his problems complicated by the reactivation of childhood difficulties. The help that he gives may be that of demonstrating to the patient that he can form a trusting relationship with a "father"

figure. The chaplain demonstrates concern. He shows that he cares. He shows that he is strong enough to accept the patient's hostilities and to handle his angry outbursts calmly. By the chaplain's reaction, the patient will see that his rebellion can be accepted and understood. The minister does not pose as the "perfect" father, but shows that he can understand how the patient feels and, therefore, can accept his childish attitudes.

As the chaplain demonstrates to the patient that a "father" figure can be trusted, he takes the place of the father with whom the patient had his original difficulties. If the chaplain supplies the patient's childhood need to be accepted without having to earn acceptance, he helps immeasurably. When the patient is willing, because of a good relationship with his father in his early years, to accept the voice of authority the chaplain's work is made easy. By accepting the fears of the preoperative patient and by conveying, more with his attitude than with his words, his own assurance, the chaplain can strengthen the patient and help him meet the surgical threat. The chaplain helps the patient by assuming the position of a good father. It is interesting that often in these cases the nurse appears to take the maternal role for the patient. The chaplain and the nurse working together with a surgical patient can be an effective team.

When a patient rebels irrationally against the "father" figure, represented for him by the chaplain, the chaplain still works the same way. He accepts not only the patient's fears, but his anger, and shows the patient that he is strong enough to absorb such punishment. As the chaplain shows his own emotional strength, some of this strength is conveyed to the patient. The patient finds that, contrary to his earlier experience, the "father" figure can be trusted. He then tends to meet the surgical threat more adequately. The chaplain, by his compassionate presence and approach, helps to lead the patient through to the ability to accept the reassurance of a "father" figure. The work is all done here at the level of the patient's regression. The chaplain accepts it. He realizes that the patient must be allowed to regress in such a stress situation.

Some authorities suggest that tne hospital chaplain ask what is, for convenience, called the "surgical question." By this, they mean the preoperative patient should be given the opportunity to talk about his feelings. There is clinical evidence to indicate that the patient who thinks specifically about his operation and his fears connected with it tends to handle the operation much more effectively than one who has not faced up to it. Patients are inclined to try to ignore the possibility of pain, or body damage,

or death involved in surgery. If the hospital chaplain visits a patient who is facing major surgery and finds that he is overly cheerful, he can speculate that there is some work yet to be done. Janis refers to this work as the "work of worrying" as compared to the "work of grief" or "work of mourning" necessary after a person has lost a loved one. The "work of worry" can be assisted by a simple question such as: "I wonder how you feel about your operation?" A lighter way to approach the matter is simply to state, "I understand your party is scheduled for in the morning. I wonder how you feel about it?" The chaplain should discuss the matter with the surgeon in charge of the case if there is any question about such a course of action. In the book *Psychological Stress* there is clinical evidence presented to uphold this conclusion. Janis classified patients facing surgery in three categories: those with high anticipatory fear; those with moderate anticipatory fear; and those with low anticipatory fear. He found that patients with high anticipatory fear were probably in such a state due to the reactivation of childhood conflicts. He found these patients inclined to go into a depressive state, or one bordering upon depression, after the operation. With the patients with high anticipatory fear, he found it of little value to draw attention to their operation, as the fear they had was too intense to be dealt with in such a way. On the other hand, he found that those with low anticipatory fear seem to need to be allowed to think specifically about the threat ahead of them. Those who denied having any fears were inclined to be quite hostile toward the hospital environment after surgery. Those with low anticipatory fear tended to use superficial techniques in dealing with fear. They denied being afraid. They talked about how much better they would be after the operation. They tended to use self-conscious religious expressions as crutches in facing the surgery. These patients with low anticipatory fear told themselves everything is going to be not only all right, but more all right than ever. Then when the shock of surgery was experienced, and the pain attendant upon convalescence had been seen for what it was, they reacted with anger toward the hospital staff and refused to cooperate. Their inability to cooperate slowed down their recovery. The third group, those with moderate fears, dealt with the actual fact of surgery much better than the others. These people had certain fears. They were worried about how they would be able to stand the pain. They wondered if it would last 2 or 3 days, or more. These people thought in terms of what might happen to their lives if the surgery failed. By thinking specifically about the fears, they were able to deal with them as they came. Even where the actual disturbance was greater than they had ever expected, they

were still better able to deal with it. It begins to be apparent that possibly the "surgical" question is most important here. If the patient who denies the existence of fear at all can be given the chance to face it, and to think specifically about it, he can be strengthened. As the chaplain continues in his work he will begin to find out more about which patients ought not to be asked such questions, which patients are already asking it, and therefore, don't require the question, and those whom he can safely guide to a consideration of their fears. He should, of course, coordinate closely with the responsible medical authority. It is interesting that Janis, in coming to the conclusion that some new professional assistant must be developed to help people facing surgery, does not think in terms of the chaplain. It seems that the hospital chaplain would be best equipped to help people face the threat of surgery. This, however, may require more training than many hospital chaplains now get. Janis points out the need in the following sentence: "Obviously, if any quasi-therapeutic techniques are evolved for dealing with neurotic personalities, psychological preparation may have to become a specialized professional activity to be carried out by clinically trained personnel who are sensitive observers, skilled in dealing with emotionally distraught people."[4] Certainly the military chaplain should have the basic qualifications for such a role.

After the chaplain assists the patient in facing and handling the "work of worrying," he must be prepared to answer certain questions and to advance certain facts. This does not mean that the chaplain should talk specifically about surgical techniques, or about patients he has known in the past who have undergone such surgery. Some of the facts he may give are: that fear is apparently a normal accompaniment of surgery; that the person is not alone in the fact that he is afraid; and that a certain amount of discomfort is not out of the ordinary. Knowledge such as this will help the patient to feel a sense of oneness with others and will keep him from being surprised by what does happen. The chaplain may go further to state that he intends to see the patient regularly both before and after the surgery and during the period of convalescence. This assures the patient that he will retain continuity with an authority figure he has come to accept. The person now knows he is not facing his problem alone and gains strength from this knowledge. It is perfectly all right for the chaplain to reassure the patient, before surgery, about the skill of the surgeon and his recognized ability, where he is honestly convinced of the fact. A word from an authority figure after the

[4] *Psychological Stress*, Irving L. Janis, John Wiley & Sons, Inc., 1958, p. 381.

relationship has been allowed to develop can be quite encouraging. If the patient can go into the operation trusting God, his surgeon and his chaplain, he can face the threats involved more adequately. It must be made clear that the attempt to reassure must not be overdone; the facts must be dealt with realistically, so that the patient will not be angry towards the surgeon and the chaplain for misleading him.

The need for careful preparation appears even more evident with regard to patients facing heart surgery. It is not by chance that the heart has had the place it has had in literature through the ages. It is not by chance that life is tied up with the operation of the heart. Should the heart fail, life goes. The fact is deeply embedded in the human mind.

Persons who have had heart problems develop certain specific fears. To the heart patient, surgery is indeed a threat to life. No matter what statistical studies could be shown the patient it would not reassure him to know that many people go through such surgery without adverse result. One of the problems involved with heart surgery is that with any condition which has been chronic, which has forced the patient to take certain precautions in life, there is a tendency to use the disorder for secondary values. Thus, a patient who does not like hard work may find it pleasant to have to take care of himself. The woman who really does not wish to have children may find a heart problem a good excuse for protecting herself from such a threat. People tend to make use of their disorders and to build their lives about them. If successful heart surgery is going to restore the patient to a full-duty status, either in the home or in the unit, it is obvious the patient should be prepared for this. Where the attempt to build a life around the disorder has not been too complex or too prolonged, the chaplain should be able to help. Where the arrangement of living is too deeply ingrained in the thinking of the person, he may have to ask for psychiatric help. In patients with heart surgery which has been successful there has been a tendency toward retention of symptoms. Here the danger is evident that the patient may reorganize his lift to fit in with the disease and, in a sense, "enjoy poor health." All the more reason for careful preparation. In most cases, the chaplain will be able to help the patient deal realistically with the possible outcome of his surgery.

The need to plan ahead for living beyond surgery is not limited to patients facing heart surgery. Before the operation the chaplain may help reassure the patient by encouraging him not only to face the fears connected with the surgery but to plan ahead. The chaplain can ask questions to encourage the patient to think about

life on the other side of surgery so that he is not blinded by fears of death. The chaplain can ask questions which will encourage the patient to talk about his plans, his ambitions, his dreams, his hopes. The chaplain should talk about life on the other side of surgery with the same assurance that he has toward all life. Planning beyond the operation not only will reassure the patient but, also, will help him realistically plan for reentry into life. Such planning will be seen to be necessary when it is remembered that the patient has been allowed to regress before surgery. After surgery the chaplain needs to help the patient learn to stand on his own feet. Literally this is done by the surgeon, in most cases, in modern hospitals, for quite often the patient is required to walk very soon after surgery. The chaplain must think about this from the standpoint of the future. A person must not be allowed to stay at a childish level. So if the chaplain has encouraged the patient to rely on him as an authority figure before the operation, he must become less active and force the patient to take over more of the management of his own affairs after it. The chaplain should now resist making decisions. He will not do so in words, but simply by not replying, or by asking further questions forcing the patient to examine his own thinking. The patient is led towards independence. Obviously, there is a danger here that the patient may rebel against the chaplain, but this is not too important. The important thing is that the chaplain handle fewer of the patient's decisions and encourage him to take over his own life again. In the normal case the patient will be only too glad to do this and, with the least bit of encouragement, will find his need for the chaplain to be lessened. The chaplain should have a feeling of success when the patient really no longer needs him for anything more than a few social interchanges.

Some other practical aspects of the chaplain's hospital ministry to surgical patients are now to be discussed. The chaplain should attempt to see all surgical patients he intends to follow several times before the actual day of operation. By so doing, the chaplain develops a relationship which enables him to help the patient even more. If it is possible, the chaplain should arrange his schedule so as to make a late evening call the evening before the surgical procedure is scheduled. To wait until in the morning, shortly before the operation, is taking a chance that the patient won't be able to talk at all. Early in the morning there is too much in the way of preparation to be done, and often, the patient is too heavily sedated for the minister to be of great help. But in the evening before the operation, the fears come. The chaplain can visit the patient after he has been made comfortable for the evening. The patient may already have been sedated, but should be

seen before the sedation has had time to do its full work. At this evening call, the chaplain asks the "surgical" question. The patient is thus given an opportunity to talk about his feelings about the surgery he must go through. After the chaplain has asked, "I wonder how you feel about it?", and the patient has been given an opportunity to talk about his feeling, there should be prayer. Of course, the teaching of the chaplain's own Church will dictate how much of an ecclesiastical nature will be performed at this time. Many times the Roman Catholic chaplain will want to provide last rites for his patient. Whatever is required by the Church should be known by the chaplain and the need met before surgery is faced. Prayer with the patient on such an occasion should include thoughts about the kindness and compassion of God; the skill of the surgeon; tenderness of the nurses; and a phrase indicating that the chaplain is thinking beyond surgery to an active life if such is at all possible. Obviously, the facts surrounding the individual case will determine a large measure of the content of the prayer, but it should be designed to help the patient to relax, to go to sleep with a feeling of God's constant care, and to think in terms of God's love as being uninterrupted by the surgery or whatever happens at that point. Clinical experience substantiates the wisdom of tradition by recognizing the need to incorporate an act of confession in the work with the ill. Those chaplains who represent groups with carefully structured acts of confession accompanied by the assurance of forgiveness are most fortunate. Those representing groups leaving such matters to the individual have a need to work out their own approach to the matter. Perhaps, such material can be incorporated in the prayers with the patient. After an experience of confession, accompanied by a sense of having received forgiveness, patients often find new strength welling up within.

The chaplain should make every effort, also, to be available to the patient after the operation. In some cases, he will go into the recovery room. In others, he will find it better to wait till the patient has been returned to his ward or at least the recovery ward (as opposed to the recovery room). As soon as possible after the patient is conscious and able to deal with anyone, the chaplain should make himself available. At this point a very brief prayer might be offered, a word of encouragement given, and then the chaplain should depart as the patient tends to tire easily. After the operation, as has been pointed out, the chaplain should encourage the patient to become more and more independent each day. It is difficult for some clergymen to lead a person to independence, because they have the need to have people dependent upon them. If the chaplain understands his need, he may be able to over-

come it. If he is not able to overcome it, he should consider some work other than that of a hospital chaplain, because people can be damaged by encouraging their dependency when reality no longer demands it. Only when there is a specific need to encourage dependency, as in the period before surgery, should it be done. The period of dependency should be carefully limited to meet the needs of the patient, and then the patient should be led in the direction of independence.

21. Summary

The hospital chaplain will find a good deal of his time will be spent in surgical wards. If the chaplain has had combat experience, he will already be prepared for this work, as the threats of surgery are similar to those of combat. Remember that the patient faces the threat of pain, of bodily damage, and of death. Take what steps are practical to help the patient with these fears. Remember that the surgeon and other hospital personnel may not have the time to help the patient with his emotions, and that this is a realm in which a minister can function well. Careful attention to work in the surgical ward will lead to great gains for the patients and to the sense of a job well done for the chaplain. The chaplain should, of course, try to know the surgeons who are on the hospital staff and how they work. There are times when the surgeon will need ministerial help. There are times when pastoral listening can well be used with doctors. When a doctor inadvertently loses a patient he tends to blame himself. A chaplain who is willing to listen and not preach, can be most helpful at this point. If the chaplain proves himself to be sensible, valuable, and dedicated in his work with the hospital staff, they will be more than glad to have him work directly with their patients. Indeed, the chaplain will find that he is getting more calls than he can handle. It needs to be pointed out that the chaplain best works with a selected few rather than with trying to make short calls on everybody in the hospital. Hospital work is not a matter of reporting statistics. It is a matter of helping individual patients in great need. Certainly, there are an abundance of such persons in the ordinary surgical ward in any hospital.

SECTION VII
THE ORTHOPEDIC WARD

22. Special Considerations

The patient on the orthopedic ward shares with other patients the problems of normal hospitalization. He experiences the problem of isolation and the sense of rejection that goes with it. As any hospital patient, he tends to regress. Since it is the first time for sometime that he has had an opportunity to think, other problems in his life may assume a new importance. As always, the problem and task of the hospital chaplain is to help the patient identify his area of greatest need and help him work through the immediate problem. This makes a demand on the chaplain which calls forth his best talents. It is not necessary to go again into the general problems of the hospitalized, but it might be helpful to think a moment about some specific problems which may tend to complicate the life of the orthopedic patient.

Any injury to the limbs may be equated to the loss of that limb. A loss of a limb or any portion thereof, or a threatened loss, creates many problems. Such a loss, or the possibility thereof, is often experienced in the same way as the loss of a loved one. Many students in the field are convinced that this sense of loss is the same as that experienced in bereavement. The patient must go through a certain amount of emotional work similar to that which is known as the "work of grief." The patient must learn to objectify his loss. If his activities in the future are to be restricted because of his difficulty, he must face this and make plans concerning it. The loss must be accepted. Whether this is a loss of the limb itself, or a loss or impairment of the function of it, the problems are similar. The patient must revise his own feelings of worth or worthiness. His view of himself as a person is damaged by the blow to the structure of his being. Nothing but trouble is to be gained from refusing to discuss or deal with the loss. The way in which the body rebels against such loss is often seen in the way in which pain may still be felt as though it were coming from a limb that has been lost. Pain from a "phantom" limb is as real as any other pain. The mind and body working together may attempt to reject the acceptance of loss. Such a rejection of the reality of loss can only complicate life. The compassionate

chaplain must strive to find strength enough to encourage the patient to talk about his loss. The chaplain should encourage the patient to face up to the grief work he must go through related to the injury, or the loss of limb, or the impairment of function. He must demonstrate acceptance of the person in such a way as to enable the patient to find a new belief in himself. Once a patient has been able to face the fact of his loss, to readjust his thoughts about himself to fit in with the present reality, and to plan for life in accordance with this new limitation, he may find a new sense of meaningfulness. Books of sermons and books of case studies are full of instances in which a person who has been impaired in function becomes more effective in his life's work and has a new sense of purpose. Certainly, it is an important thing for a chaplain to be able to assist a patient in such an experience.

The principle remains that only trouble can be caused by refusing to face a problem. The facing of the problem can be made easier by the presence of a chaplain who is understanding and accepting. The hospital chaplain should plan to spend as much time as possible in following up on orthopedic patients. Many times they must continue in an out-patient status to return to the hospital for checkups. It is a good idea in many cases to arrange for an out-patient visit with the chaplain to coincide with the visit to the orthopedic section.

The orthopedic ward is often full of patients who have received injuries in accidents. Quite often there are guilt feelings connected with the accident. Where there has been heavy drinking or reckless driving, the patient may need to face his own implication and involvement in injuries to others as well as to himself. The chaplain must not avoid the question of guilt, but should emphasize also the redemptive characteristics of his faith. An error accepted and faced can lead to a new development in character. If the patient needs to face his guilt and does so, and experiences a sense of forgiveness, what seems to have been a low point in his life may turn out to be a high one. The chaplain, within the teachings of his own Church, should work to assist such patients in working through their problems of guilt and forgiveness.

The chaplain working in the orthopedic ward will also find the problem of boredom. He should remember that while there are recreational workers and occupational therapists who are trained to help patients express their emotional needs, the chaplain can also assist. He can do so by encouraging activity, by arranging appointments with recreational specialists, by referring such people to the specialist concerned, and by continuing to express a friendly interest in what the patient does. During a long con-

valescence the chaplain may serve by recommending certain readings for the patient. In many ways, he can demonstrate such concern and such compassion that the long days required for the healing of broken bones can be passed to some advantage.

Intense pain is often a companion of the orthopedic patient. Injuries to the spine can create excruciating agony. Often it is impossible for the patient to become comfortable. While the patient is undergoing such pain he will certainly not be too convivial. Yet, the chaplain should not pass idly by. He should find time to sit for a moment with the patient, making no demands upon him for conversation, but simply stating his interest and his desire to be of help. Sometimes a patient in pain questions God's love. The chaplain must not let his own fear of pain unsettle him in his work with such patients. He should quietly accept the patient's questions and not try to answer more than he can answer with real authority. Remember that the person with pain is the authority about that pain. No one else can tell him how much pain he is experiencing. There are few who would say that, "all pain is creative." Some deep-bone pain can be devoid of immediate meaning. All of the theories about the meaning of pain, and its function as a warning to enable a person to avoid threats to his own life, become meaningless when one is dealing with extreme cases. Further, it is useless where real agony is met to talk in terms of the higher expressions of personality which come from effectively meeting pain. Such statements are usually made by those who have not had to face severe, unrelenting pain. It is far better to simply accept the patient's own statement of his pain and his feeling about it. Quietly accepting it and entering into his pain with him empathetically as a fellow human can lead him to a more optimistic attitude. If he feels that he is rejected because he is rebelling against his pain and asking blunt questions of his Maker, it is hard for him to be helped. If, on the other hand, he feels that he is being accepted by one who cares for him and who represents God, then he can make an adjustment in his thinking, an adjustment on the side of life.

Many times orthopedic patients have emotional difficulties. The relation, for instance, of back pain to the emotional well-being of a person is well known. The person who feels "down in the back" may be saying that he feels depressed about life itself. He may be either fleeing into sickness or utilizing his difficulty for its secondary values in making it unnecessary for him to face up to life. The determination of such pathology must be left to the doctor who may also be working with the psychiatrist. The chaplain should remain open for consultations with both specialists and show his willingness to work in any way possible to help the

patient toward health. Constant communication with those in charge of the ward is here most important. The chaplain should not forget that the nurse is often his best friend in helping him make his work more effective.

23. Summary

The orthopedic ward is not just a factory for mending broken bones, it is a section of the hospital where there is deep human need. The chaplain's own resources of faith in life will be drawn heavily upon in such a ward. Here, also, the chaplain will learn probably as much about the problems of life as he will in any part of his work.

SECTION VIII
THE NEUROPSYCHIATRIC WARD

24. Special Considerations

Psychiatric patients present to us, in an exaggerated way, problems which in one form or another are normal and are faced by us all. Since the hospital chaplain may see before him his own particular problem full-blown, he may feel threatened. Society still has not attained an intelligent attitude toward emotional disturbances. Society, as a whole, still tends to look down upon a person who is mentally ill. This fact may be seen in the terms which are sometimes used even by doctors in a moment of anger. Professionally-trained personnel sometimes refer in scathing tones to a patient who is chronically ill. Some of the intensity of our reaction to the mentally disturbed is related to our own problems and our own fears. If the chaplain recognizes some of his own problems and how they affect him, he can overcome their damaging effect to some extent. To help the mentally ill, the chaplain must be seen as a compassionate person who views the patient as a person in trouble and worthy of the best that he can offer him. When it is recognized that some feel that most mental illness is caused by a failure of the environment to provide love for the person involved, it becomes even more evident why it is necessary for the chaplain to be a person who cares and can be trusted. If the patient has never been helped to think of himself as a person for whom others care, it is evident that the chaplain will be challenged to correct this lack in the patient's life. The religious man may be the only one who is motivated strongly enough to see a very disturbed person as a fellow human being. Many times doctors, who have many demands upon them will tend to pass by those they feel they cannot help. The chaplain has a unique role to fill with these people. The Protestant clergyman, Roman Catholic priest, and Jewish rabbi believe that God loves all of his children. The man of faith believes that, whatever accidents or illness occur in our lives, we remain God's children. Possibly this view of the importance of man, and the worthiness of men in the sight of God, is one of the strongest therapeutic ideas in the world. Here then, in his work with the psychiatric patient, the hospital chaplain rises to the heights of his calling.

The chaplain needs to be assured of the value of his role as a clergyman. If he believes that as a man of religion he has a power to convey to others which they cannot receive from any other source, he will be most effective in his work with psychiatric patients. The chaplain is not to play at being a psychiatrist; he is not to perform as a psychotherapist; he is not to conflict with the doctor and his task. The chaplain is to be the chaplain. In his religious role, he can bring to the tragic situation a source of strength no one else can offer. Whatever the patient receives as therapy, he also needs emotional support. He needs to know that there are those who care about him whether he gets well or not. He needs to know that he is worthy of the love and respect of others no matter what happens. The hospital chaplain can help supply this need. Many times the hospital chaplain will represent the patient's only contact with the world outside. The doctor is a part of the hospital environment. The chaplain is part of that environment, but he also represents the world outside the walls. The chaplain reminds the patient of his own Church, of his own chaplain, of his own contacts with his family in better days. This being the case, the chaplain has a role which is most valuable. He is a bridge to the world outside and may, indeed, be a bridge to better days ahead. Often this fact is recognized solely at an unconscious level, but, nevertheless, it is recognized by the patient. Of course, if the patient's contact with the outside world, as represented by the chaplain, has been all bad, the chaplain must be prepared to absorb a great outpouring of hostility. If the chaplain has strength enough to accept such aggression, the patient can be helped to a better contact with his world.

Part of the strength the patient will receive from the chaplain will be the strength simply to bear the treatment that he is getting. If the patient is receiving some form of shock treatment, he is likely to need reassurance that such treatment is finally helpful. He needs assurance that he can tolerate the treatment. He can receive such assurance if he has faith in the chaplain, and his faith in the chaplain should grow as the chaplain continues to minister to him. If the chaplain knows the schedule for the patient's treatments, he should make himself available before and after each one. His contacts and his prayers will tend to help the patient face the demands of his treatment with new strength.

While the patient has a demand upon the chaplain's time, so, also, do the patient's dependence. He may often be their only contact with the patient. Since the patient's family is often implicated in his illness, the doctor may not want him to have many direct contacts with home. The chaplain can meet the family when they come, sit with them and encourage them to talk about

their feelings, encourage them to examine their own attitudes towards the patient, and to plan for days ahead when the patient returns to his normal tasks.

Often the family of the psychiatric patient unconsciously recognizes its involvement in his problem. Therefore, the defenses are up. The chaplain must be prepared to hear many accusations against the person who is ill. He must expect a certain amount of hostility. After all, as the family sees it, the person's illness has become a reflection upon them in their work and in their communal life. If the chaplain does not hear such hostility expressed directly, he may recognize it indirectly in profuse protestations of absolute devotion to the patient. Many people are not able to deal directly with their guilt feelings and, so, compensate through a reaction formation. Thus, if they do feel that they have mistreated the patient and, perhaps, contributed to his problem, it may be necessary for them to assure themselves and everybody else of their absolute, undying affection. The pathology of this protested love is seen in the excess in which it is pressed. As the chaplain continues to listen, he sees, mixed with all of this love, a great amount of venom. Nevertheless, the best way for the chaplain to handle such hostility, whether it is directly or indirectly expressed, is to hear it out. The remarks made earlier concerning ventilation apply here.

The chaplain's work with the family can help them plan for days ahead. They should be encouraged to consider all possibilities. He can help prepare them for problems they may have with their own feelings later. It may help them to know that the community may have difficulty accepting not only the patients but the rest of the family because of this problem. It does no good to pretend that such problems do not exist; it is much more helpful to face them. This does not mean that the chaplain need continually confront the family of the psychiatric patient with such facts. If he gives them time and helps them to trust him by listening to them with compassion, they will bring these problems out in the open themselves.

Probably one of the least helpful roles that the chaplain has with psychiatric patients is carrying word from the family to the patient and back again. Sometimes it is best for him to carry only the most general information, as for instance, "I've been seeing your family. They are concerned about you and want you to know that they are thinking about you." And the same is true in messages from the patient to the family.

Although it may be that the doctor may, at one time or another, not want the family to see his patient, he, nevertheless, wants the

family to call. There will be days when they can see the patient. When they can't, they can see the doctor and learn something of his feeling about the situation. It is when the family stops caring enough to investigate the well-being of their family member that hope leaves. The trend now is toward avoiding institutionalizing patients over long periods of time. If the illness can be controlled so that the patients are not dangerous to others, or to themselves, they are released, as soon as possible, to the care of the family. There are not enough institutions to handle all of the mental patients. As in the case of paralytic patients, quadriplegics, and paraplegics, so with the mentally ill, the care will finally have to be assumed by the family. This means that families must be encouraged to keep their sense of responsibility for their own. It also means that trained ministers must prepare the family for the demands that will be placed on them. It must be pointed out that no matter how willing we are, we are limited by fatigue. We can only "give" so much of the time; if we do not "receive," it begins to tell upon us as persons. If we know this, and we are not confused into neurotic guilt feelings because of our difficulties, we can meet those difficulties wisely and well. The hospital chaplain should do what he can to teach these facts to the families of psychiatric patients.

Another word of warning with regard to our work with the emotionally disturbed. The chaplain should avoid getting entangled in the intellectual content of his patient's problems. He should have enough faith in the doctors of his institution to recognize that when they have diagnosed a person as emotionally ill and in need of institutionalization, they have reasons for this. So often, for instance, a paranoiac patient can make such a good case against his family and how they plotted to get him out of the way, that an inexperienced chaplain may be misled. This happens not only to chaplains but to psychiatric social workers, psychiatric nurses, to trained personnel of all professions. The chaplain does not say that what the patient is telling him is false. But he does not accept it as true either. He handles it best by conveying to the patient his understanding of the patient's feelings. The chaplain should try to get over the idea to the patient that, granted his understanding of the facts of his environmental situation, it is natural for him to feel as he does. So the chaplain helps by recognizing the underlying emotions of the patients and by expressing and conveying in verbal and nonverbal ways his understanding.

Too much concentration on the intellectual content of what one is told may be confusing rather than helpful. The chaplain does not help a mentally disturbed person become well by trying to

enter into his pathology. We do not help people by "humoring" them. The doctor, the chaplain, the other workers in the ward may be the last hope the patient has for some contact with reality. Therefore, they must hold to reality and not play games at such a tragic time.

The chaplain is most helpful in the psychiatric ward when he emphasizes the redemptive role of religion and his role as a representative of religion. This does not mean that he accepts the patient's verbal formulation of his religious problem. Often the delusional material the patient will furnish is quite rich and bizarre. Since, in one way of speaking, religion is the sum total of our attitudes toward life, it is not strange that when one has a disease of attitudes, the religious content of his problem becomes rather weird. The chaplain will not put aside his own theology and accept the patient's view of his illness. He will, however, recognize that even the most bizarre religious expression is still "religion," and he will accept the fact that the patient is groping toward real answers to serious problems. The answers which the chaplain can give at this point will be found in the demonstration of concern and compassion, rather than in lengthy harangues. We can get more of God's love over to persons by caring for them then we can be preaching to them.

In his work in the psychiatric ward the chaplain should maintain close contact with the doctors and nurses, as well as with other ward personnel. To make certain that he is not conflicting with the psychiatrist, the chaplain should contact him to see if it is medically advisable for him to call on an emotionally disturbed patient. In most cases, his right of access to the patient will not be contested and his cooperation will be appreciated. There are some cases where religious matters are so involved with the patient's pathology as to make it impractical and unhelpful for the chaplain to see him, and this the psychiatrist can usually explain to the satisfaction of the chaplain. Where the chaplain demonstrates his concern for the welfare of the patient, the doctor will be alert to opportunities to seek out the chaplain and request his cooperation. It is doubtful that a patient can receive much help from either if both psychiatrist and chaplain are using his case as a mutual battleground. However, where these two professionally trained individuals work together cooperatively, the welfare of all the patients is promoted. The chaplain may be asked to take part in evaluation and other conferences and to work with outpatients as well as with in-patients. The chaplain and the doctor, by consulting together, can determine the role which they feel should be the chaplain's in each individual case. Obviously, the chaplain will be more helpful with some than with others. The

doctor may want the chaplain to be more active with some than with others. In some cases, the chaplain's work will approach psychotherapy; in others, it will be the provision of the sacramental rites of the Church; in some cases, it will include the use of prayer, the sacraments, and an attempt to help the patient think through his own religious problems. In some cases, the chaplain's role may be simply that of emotional support. In each case the restrictions are placed upon the chaplain not to limit his work but to make it more effective. In other words, together with the doctor, he can find that area in which he might be of most help. Continual reevaluation will be necessary, as often the demands will change. It is best for the chaplain not to conceive of his work rigidly. If he feels that he must work with each patient towards a verbalized recognition of guilt, a statement of repentance, and an acceptance of forgiveness, he may be destructive in the psychiatric milieu. One of the facts about mental illness is that instead of it allowing an unlimited free expression of personality, it represents a rut from which there is no escape without medical assistance. The patient, himself, is rigid and is unable to break his pattern. If the chaplain feels the same way, his value is limited. The chaplain must be spontaneous, resilient, and pliable. As he continues to work with psychiatric patients his courage will grow, and he will come to learn that the greatest mistake is not to care enough to offer his help. The chaplain must have some emotional maturity, for he will soon realize how threatening it is to recognize the fact that he is a part of the delusional pattern of the patient. If he is addressed as a member of the F.B.I., as a Communist, or as the President of the United States, he must not be caught off base. He will not admit to any of these titles, but he will not be shocked nor surprised when he is so addressed. His calm, good-natured refusal to be anything other than himself will reach the patient eventually.

In most of our military hospitals mental patients are not kept for long periods of time, but some chaplains in our larger installations will be faced with continuing demands in this field. If the chaplain is not expected to save the world in any prescribed period of time, and if he is willing to work without the immediate awareness of success, he may find his work with the psychiatric patient extremely valuable to himself as a person. If he is willing to represent God's love in the midst of tragedy and to give of himself in many difficult situations and find pleasure only in the giving, his work in the psychiatric ward will be the high point of his life. However, if he plans to save the world, either by preaching or by theological argumentation, he had best look for other work.

25. Summary

Working together as part of the team with the doctors, nurses, and other trained personnel, the chaplain may add much to the therapeutic possibilities of the neuropsychiatric ward. Over and above the therapeutic possibilities in the chaplain's role there is, of course, the greater possibility of relating the patient to One whose care and whose love is eternal and unchanging. Thus, it is important for the minister to realize that his role as a representative of God is, in itself, the most important offering he can make.

SECTION IX
THE PEDIATRIC WARD

26. Special Considerations

Even at small posts the chaplain will ordinarily find a ward in the hospital set aside for children. Many of these children do not attend the chaplain's service of worship, and he has no contact with them except in the hospital. His work will probably be more effective where he has had other contacts with the child and with the family, but often he will have to begin as a stranger in a strange situation. All the more reason for him to plan carefully for coverage of the pediatric ward. A lonely child is quite often a frightened child. The limited experience of the child means that he will have many questions about his environment. The child will take most of his attitudes toward the environment from the adults with whom he is associated there. Thus, a cheerful, strong, calm hospital chaplain may be able to convey, by contagion, helpful attitudes to the child. If the child can learn to trust the chaplain, the nurse, and the doctor, his period of convalescence will probably be shortened. Attitudes of trust and hopefulness are effective therapeutic aids. Thus, by the inculcation of the proper attitude in the child, the chaplain cooperates with the healing force.

When a child is away from home, any adult can become a substitute parent. The child has learned to look to the adults about him for help and for some key as to the way he should feel. If a chaplain is frightened himself, and if the prospect of working with the sick child creates acute emotional reactions within him, it is difficult for him to help in the pediatric ward. However, normally, the chaplain is one of the best aids for the pediatrician in his work. Many physicians, whose aim is the practice of pediatrics, have the "shepherd heart" and approach children with calmness and understanding. This does not mean that the chaplain is not needed, for every added help is valuable.

Obviously, the chaplain's ministry to the child is not primarily an intellectual one. Here, even more than with the adults, it is necessary to practice compassion, rather than to talk about it. The chaplain becomes the love of God; he does not talk about it. The tendency of many chaplains will be to try to answer a child's

question at a deeper and broader level than the child ever intended. The child's question should be dealt with simply and honestly and limited specifically to the question itself. Because a child asks why he must have pain does not mean that he is ready for a long talk about the problem of suffering. If the chaplain is warm, friendly, and optimistic, without being overly effusive, the child will trust him and trust the situation.

The ministry to children requires a certain amount of imagination. Some men like to carry with them small gifts, such as balloons or lollypops, so as to lighten the child's eyes by making a gift. It is doubtful whether or not this is the best procedure. If candy is given, it may be bad for the child's teeth or may conflict with his diet. If balloons are given, they can become threats, for if sucked into the child's lungs death can result. Since the chaplain appears as a representative of God, he should not deemphasize his importance. This means that he should not let the child see him as one whose primary role is to give tiny, material gifts. Let the chaplain be seen as one who dispenses understanding, counsel, and love. This does not mean that all gift-giving is precluded, but, rather, that it should be carefully thought about. A simple game which can be understood by the child and played by himself alone may help him to while away many lonely hours and, thus, free the nurses from excessive demands. Nothing should be given which would tend to disrupt the ward. In some cases, tiny airplanes have been given causing a great amount of turmoil, as it is out of the question to give a child something and then ask him not to use it. The point is that the minister must remember that his personal contact with the child is what ought to be interpreted as important.

The chaplain has a good opportunity to shape the reaction of the child to the Church for the rest of his life. The child knows very little about a minister and, ordinarily, has seen him only in a chapel at a time when the child is bored. He may see the minister as a man who talks to crowds or conducts services. He may view him as a man of "magic," following the lead of other children in the community or that of his parents. If the chaplain finds some way of making clear to the child what the purpose of the ministry is, he may enable him as an adult person to have a much more effective relationship to the Church than he ever could have had before. In other words, if the chaplain handles his contacts with the children in the hospital effectively, he may assist them to come to the Church for the help they need for the living of this life.

Often, physical contact with children is important. If the child is frightened or in pain, to sit with him and to hold his hand, or to place an arm easily and comfortably about him, may be more re-

assuring than all the words one could possibly utter. In dealing with the adult patient physical contact is not to be desired, except in rare cases, but with the child it is an important part of the ministry. Thus, with nonverbal communications the chaplain can help the child not only in his present situation in the hospital, but can make it possible for him to gain the help he should receive from the Church throughout the rest of his life. Care should be taken not to violate the religion of the parents. The chaplain should not talk about specific doctrines of his own Church with the child unless the parents ask him to do so. It is important to avoid difficulty between the child and his parents and not to interfere with whatever religious instruction he may be receiving, but, rather, to supplement it by a demonstration of the love of God in human relationships.

While working with the pediatric ward the chaplain finds a good part of his ministry is to the family. Much time is spent with the mother who is able to be present more often than the father can. With many children's ailments and difficulties there is a great feeling of guilt on the part of the parent. Mother feels that if she had been present the child would not have overturned the pan of hot water. Mother knows that she should not have let the child go across the street without help. Mother also realizes that if she had seen that the child had received his shots on schedule, he would not be faced with the disease he now has. With children who have been born with some sort of physical impairment there is often some magical feeling of guilt on the part of mother, accompanied by the feeling that God is punishing her through the child. These feelings may all be experienced by the father, also. Realizing this, the hospital chaplain will make himself available to the family of the children so as to help them to a clear and rational understanding. Where guilt is real he can uphold the promise of God's forgiveness. Where guilt is neurotic he can spend enough time with the person to help him recognize this fact. If the neurotic guilt is too deeply embedded, he may want to make referral to the psychiatrist. Such a referral is a very difficult one to make, as the chaplain must not let himself be charged with saying that the family member is mentally ill. The wise and well trained hospital chaplain will be ready to spend a lot of time with the families of children who are hospitalized. A good point to remember here was discussed as focused listening (par. 5*c*). By this, it is meant that the chaplain must remember to let the mother or the father talk about his or her own feelings and not always about the child. Remember that where children are hospitalized there may be other children who are not getting the care they should, because of mother's presence in the hospital. It may be helpful for the

mother to find the strength to stay away from the hospital for some visiting hours to make her energies available to the children at home. Some parents cling to the bedside of the child because of the guilt feelings already discussed. The chaplain recognizes that parents have a right to their own feelings. If parents have been staying up late and taking time ordinarily used for their own recreation or rest to be with the child who is ill, it is only normal for them to experience some resentment. If the parent is unable to recognize such resentment and accept it as normal, he may be frightened by it. The chaplain should enable the parent with whom he is dealing to talk about his or her own feelings. Constant statements such as, "How is the child getting along," "I know it's difficult for the child to go through this" and others of this nature should be avoided. If statements are to be made they should be those which center on the person whom you are with, not on the one who is absent, such as, "This must be pretty tiring for you," or "This can't be easy for you." A grateful response will usually ensue.

Another warning about dealing with children in the hospital is simply to remember that children are persons. Adults are often inclined to talk loudly in the presence of children about matters which they feel the child does not understand. It is better to assume that the child will either understand or distort what he hears, so that such statements can become even more frightening than they normally would be. If the chaplain and the family intend to talk about the child they should move out of his hearing or should include him in the conversation.

Work in the pediatric ward can be very threatening to a chaplain who has his own children. However, by the same token, such work can be tremendously rewarding. Whatever the faith of the chaplain, he represents to the child the love of God. Such a knowledge should send each chaplain about his work with a new sense of humility.

27. Summary

Close cooperation with the doctor is important in all cases. Such cooperation is certainly important with children. It is difficult to know how ill a child is or what precisely is bothering him, since he often cannot tell you himself. Therefore, it is wise to work closely with the nurse and the doctor so as to know the diagnosis and the prognosis concerning the individual child. Doctors and nurses, alike, will be appreciative of the chaplain who calls continually in the pediatric ward. This appreciation will, certainly, be felt where the chaplain demonstrates his sense of responsibility and his ability to work well in such an environment. When the

chaplain is observed at his work with children and is seen to work with kindness and compassion, he also wins those who watch him to a better relationship with their Church. Thus, the chaplain in his work in the children's ward can minister indirectly to the nurses and doctors and other ward personnel who observe him.

SECTION X
THE WOMEN'S WARDS

28. Special Considerations

The military chaplain will often see his duty as one directed, primarily, toward men. Yet, he must not forget his responsibility to female personnel and to the female dependents of the military. Even the small post hospital will usually have at least two wards set aside for women patients; one for obstetrics and one for other problems. Most hospitals will have more than these, but these at least will be found. The importance of regularly scheduled visits in the women's section of the hospital is clear. Women are, by nature and by training, more open to a direct religious ministry then are men. Aesthetically, women generally feel the need for the performance of religious sacraments more deeply than men do. The chaplain may represent, to women, not only God, but also the "all father." The need for masculine interest and for a masculine ear in which to confide is a predominant one among women. Since the women of the family often strongly influences the religious training and attitudes of the rest of the family, the chaplain should not underestimate the value to the Church in his contacts with female patients. He will think of his ministry, certainly, as primarily, one to the individual concerned, but he will wisely recognize the indirect gains to the Church when his ministry is carried out carefully and helpfully.

In deciding upon when to visit the women's wards, the chaplain should confer with the doctors and the nurses and determine the schedule for various types of treatment and nursing care. In the interest of the modesty of the patients, it will be better for him to come at some time when he is not in conflict with certain other activities. The ward nurse will usually be able to advise the chaplain as to what time of day his calls would fit most effectively. The chaplain, however, should strive for a time which does not coincide with ordinary visiting hours. His visit is a professional one and not a social one. Many times, the women patients want to see the chaplain when their husband is not there. There may be matters which they wish to hold in confidence, or which directly involve the husband, and which they are not ready to discuss with him, which they do wish to discuss with the chaplain. So, while the

chaplain is attempting to cooperate with hospital personnel, he ought also to make clear that it is necessary for him to be able to see patients when other visitors are not normally present.

Since one of the primary threats to the personality in hospitalization is the sense of loneliness and rejection, it is well to point out that quite often military personnel are not able to visit their wives as often as nonmilitary people might. When the military husband is away on maneuvers, or out for overnight training, or sent off on other military missions, the female dependent, who is hospitalized, can become depressed. Here the chaplain may, in a sense, substitute for the military person. This does not mean that he becomes involved with the women patients emotionally, but, rather, that he is the masculine ear to which the woman can pour out her feelings. The chaplain should not overinterpret what he is told, he should remember that in a hospital situation emotions can get out of hand, and he should not attach too much significance to the intellectual content of what he hears. A married woman who begins to pour out her hostility toward her husband may simply be complaining against the universe because of her illness and displacing her feelings upon her husband. The woman patient who turns with too much affection toward the chaplain may not be responding to him as an individual at all, but as an authority figure to whom she can relate because he is present. The chaplain should be constantly examining his own feelings because of the danger of emotional involvement. It may be easy for him to become overly involved as he projects his own past relationships with mother and other women upon the patient with whom he is dealing. If the chaplain is aware of the danger of such forces and is alert to them, he will ordinarily not become confused. However, if he has any fears that he may be becoming overly involved it would be a good idea for him to ask a psychiatrist to supervise his work for a while, or at least to get a trained supervisor from the clergy. The objectivity which he gains by going over his work with the supervisor will help him to see where he has become neurotically concerned. No chaplain should feel that he is above such dangerous involvement. If the chaplain arrogantly trusts to his own faith and his own intelligence, he may be embarrassingly let down. He should take an honest view of his own drives and appetites and recognize the danger of succumbing to them. Thus, the warning flags are up. The hospital chaplain can be tremendously valuable in his work in the women's ward, but he does need to keep his wits about him.

In his work with obstetrics the chaplain will be called upon to provide baptismal rites for infants. Often he will be called to baptize infants prematurely born. Ordinarily, the chaplain should

consult with both the mother and the father before he carries on a religious function. Sometimes patients who come from backgrounds wherein believer baptism is stressed, will, nevertheless, emotionally cry out for an infant to be baptized. When the chaplain is called and baptism is requested, where the party making the request is at all able to talk, he should encourage her to talk at some length to uncover her motivation for requesting such a service. He can thus find out something about her background as she talks. If the husband is available he should talk to him separately and get his feelings about the situation. The chaplain's stand will have to be made in accordance with the teachings of his denomination and with his own conscience, but he should move carefully and considerately. However, there are times in emergency situations when he must act. One hospital chaplain noted that when, for some reason or other, he refused to baptize infants, the nurses themselves administered the rite. In this particular rite where a valid baptism can be performed by someone who is not ordained, there is little that can be done to fight such a practice. Where such a thing is discovered, possibly some conversation with the nurses would help, but often the only outcome of such a conversation is the feeling that the chaplain does not really care about the religious welfare of his people. Such a situation demands diplomacy and tact. Unfortunately, there are no clear guidelines in such cases. With respect for the parents and the child, and with appreciation of the values of other faiths, the chaplain should, by his own conscience and his own teachings, find a middle ground which is generally acceptable.

Since the military is often seen as hostile to family life (although such a view is erroneous) the chaplain in his work with the hospitalized women of his post also performs an important public relations job. As he demonstrates his concern for the total welfare of the military and their dependents, he makes personal what is otherwise thought of as an impersonal force. The chaplain who communicates interest and demonstrates compassion performs a real service. The hospital chaplain does not exist to justify the hospital or the military post, but since he is provided by both of those organizations, obviously, they are not quite so impersonal as one might think. The chaplain should not apologize for his profession, but should merely go about his work with dignity and concern. Consistent, planned, professional, pastoral work in the women's wards of military hospitals is an important task. In this work, the chaplain makes his contribution to the total welfare of the military family. This contribution can be most significant.

29. Summary

One further word of warning may be helpful. No matter how idealistic the motivation of the minister may have been when he entered the service, he may have had a secondary motivation to escape from work with women. Many times such statements are made. Many more times the fact exists and is not admitted. If the chaplain has escaped into the Army to avoid work with women, he may find all sorts of reasons why he should spend more time in other wards and less with women. He should be very suspicious of such reasons and should examine his own feelings. With military men away in the field and on other duties, the lonely dependent is worthy of the care and ministrations of the military chaplain. Doctors and nurses in such wards are glad to cooperate with the chaplain who shows his real desire to help. Their cooperation with him will eventuate in more time for their own medical ministry. The doctor will no longer need to spend so much time in simply listening, for the minister can do this as well or better.

SECTION XI
ISOLATION WARDS

30. Special Considerations

Isolation wards are set up within hospitals for those patients who have contagious diseases in order to prevent and control the further spread of these diseases. Since "isolation" and "rejection" have already been dealt with as problems which are fairly common in the hospital, it should be obvious that in wards set aside specifically to cut off the patients therein not only from the outside world, but also from the hospital world, such problems are going to be even more intensive.

When a sick person, already cut off from the world of the healthy, is cut off even from other sick people, anger begins to boil within. Such brooding anger may be expressed against the doctor, the nurse, the chaplain, or a family member. Yet, at its roots, it is anger toward God which often cannot be admitted or expressed. The hospital chaplain may, in such cases, be a most needed bridge between the ward and the outside world. He may be the one best qualified to encourage ventilation and, thus, to draw off the poison thoughts that interfere in healing. The chaplain must not pretend to understand all of the thoughts that fester in the isolated patient, but he can show understanding by admitting that he recognizes his limitations. He may say, "I cannot understand all that you are going through, but I can recognize that such an experience must be difficult for you. I am sure I'd be quite disturbed." Such a comment, or a similar one does pick up the mood of the patient and tends to help him to trust the chaplain and discharge some of the tension that has been building up.

The rough and ready rule of the hospital chaplain "pick up negative feelings" may be false as a generalization, but, in most instances, it works well as a specific guide. The fact is that other visitors are quick to ignore the negative and encourage the patient to talk cheerfully, even if only while they are visiting. Many patients are more understanding of the needs of their visitors than the visitors are of the patient's needs. Many patients find that they cannot talk about their death fears because it is unsettling to their loved ones. They learn, courageously, to move away from threatening subjects to the weather, or how the trip to the hospital

was, was the traffic heavy, and so forth. Pain, too, is a matter that many patients try to hide from their visitors. Much psychic energy is spent in defending the healthy from gloomy thoughts. Patients need to use the chaplain as a sounding board in such matters. His faith steadies him in dark hours, and he should not feel the need to run away from the negative. He knows he will not help the patient by refusing to let him pour out his heart. Let the patient say, "I'm feeling very low today," and the chaplain replies with "I'm sure those times come. Would you like to tell me about it?" rather than "There now, let's not talk about it." Let the patient say, "Chaplain, do you ever think about death?", and the chaplain can reply with "Why, yes, of course, Why? Are you thinking about it? Why not talk to me about it. I'd be glad to listen."

The chaplain ought, also, to be able to respond to indirect leads. A patient in an isolated ward, or room, may be trying to do occupational therapy. Perhaps, he is trying to paint a picture, and he is attacking the canvas almost viciously. Coming upon such a scene, the chaplain might say, "You seem to be angry at the picture you are doing. I wonder if it is more than that. It would be natural to be angry at the whole world when one has to be cut off from it like this." Let it be emphasized, however, that the chaplain is not to force people to talk about the negative. He simply recognizes the existence of the negative thought, focuses on it almost fleetingly, gives the person a chance to talk, but goes on to other leads should the patient move away from the subject. Ordinarily, the patient is grateful to the chaplain for giving him the opportunity to explore his own thinking and, perhaps, compare it to the chaplain's. The frightened, hurt person needs someone who is strong enough to sit down with him and accept him as he is. The strength that comes from sharing trouble is often enough to promote a turn toward health, or, at least, toward a more prepared, less anxious mind.

While such a rule as "pick up the negative" is particularly in point with patients who are cut off from visits with the outside world, it is, also, a valuable aid to the chaplain with other patients, less isolated. Anger and fear sometimes lose their destructive power when they are brought out into the open in a nonthreatening environment. The chaplain does not need to worry so much about the positive. The patient's other visitors will take care of that. At least one good listener, who will not run from the negative, seems essential to the emotional poise of the patient. The chaplain can be that listener.

In his visits with the patient who has a contagious disease, the chaplain should follow the same isolation precautions used by other

visitors and the hospital staff. Following of the prescribed procedures by individuals who have contact with the patient will prevent the spread of contagious diseases and afford maximum protection to the visitors and patients. Although isolation techniques are generally standardized, the routine established at the specific hospital should be followed. This may include wearing a gown and mask while visiting the patient and thorough hand washing upon leaving the individual patient's area. Every precaution should be taken and since the patient will have been instructed regarding the purpose of the isolation techniques, they need not create a barrier between the chaplain and the patient.

Care should be taken in working out a schedule of religious services to make every attempt to provide services for those who cannot be wheeled into an area with other patients. It is most important to bring services to such wards, for part of the problem is summed up in the fact that the isolated patient already feels rejected. If the chaplain, as God's representative, also rejects him, then he is even worse off than before. Consultation with the hospital staff will be necessary in arranging for such services, but they can and should be arranged for. Piping the service into the ward over a PA system, or by any other technique, will not take the place of an actual service. Problems in individual cases may turn out to be insurmountable, but every opportunity should be exploited to act out for the person the fact that he is not forgotten, that someone still cares, and that someone represents a God who cares.

31. Summary

Many contagious diseases have their emotional component, and the emotional aspect may be the key to the shortening of the time involved in healing. If the emotional aspect is negative, the prognosis appears to be darkened. The chaplain is, certainly, one important key to the problem. His interest will be appreciated, and he will usually find complete cooperation from the medical staff, once he demonstrates his ability to work within the rules which controls the activities of others as well.

SECTION XII
THE DYING PATIENT

32. Special Considerations

No special ward is set aside for the dying patient. Yet, since the needs of the dying may be somewhat different from the needs of other patients, it might be helpful to consider them separately. In *The Art of Ministering to The Sick,* Russell Dicks has dealt beautifully with the ministry to the dying. His case material, there included, is most interesting. It must be remembered that there is a great amount of work which is done with the dying which is not structured in a book of services or in the requirements of ecclesiastical bodies. Ecclesiastical requirements will be known to the chaplain concerned. In this pamphlet, attention will be given to the nonecclesiastic work the chaplain will do.

Many conceive that the primary goal here is to assist the person to die with dignity. The living owe, at least, this much to those who are parting company with this world. Helping the dying patient to maintain his dignity means helping him to keep, always, in mind the fact of his importance as an individual before God. It means showing respect for his ideas and his views. Our work with the dying must never lead us knowingly to violate the mind of the patient. There are those, of course, who will have, as structured by their Churches, certain matters which they will feel they must take up directly with the dying patient. Such matters, of course, are left to them and to their conscience. No military chaplain is expected to violate his own conscience or the teachings of his Church.

The chaplain's work with the dying patient does not involve garrulous statements. He must be prepared to listen or to sit quietly. It is, generally, felt that with the dying patient frequent visits of brief duration are much more important than long visits scheduled daily. If the chaplain can drop in several times from morning till night for just a moment with the dying patient, he can demonstrate the fact of his concern. Since the chaplain represents God, the faith of the person involved will be strengthened by the chaplain's concern. The dying person cannot concentrate for long periods of time and, ordinarily, does not want to go into lengthy discussions, but he appreciates the fact that he is still recognized

as part of humanity and that he has not been written off the books. Death fears are heightened by the feeling of rejection the dying person is liable to feel. This sense of being rejected can best be overcome by continued contact. Thus, many visits for brief periods of time can convey much in the way of reassurance. Where it is at all possible, the dying person should be attended by a chaplain of his own faith. Yet, there is a responsibility we have to one another as human beings, without regard to our professional roles. This responsibility can be met by people of different faiths. The rule is that, where at all possible, the chaplain of the faith concerned should be present, but no one will be expected to turn aside from the needs of a fellow-human because of differences in religious faith.

Most chaplains have thought through their own feelings about death, so that they are not overly threatened by it. If the chaplain feels a compulsive need to justify God, or to avoid talking about death, except in strained euphemisms, his own faith may not be secure. He may need the help of a religious or a psychiatric adviser in working through his own feelings about death. His work with the dying patient is emotionally tiring, because he is human. But he should be able to tolerate direct conversation about the prospect of death, and he should be able to communicate compassion, rather than panic, when he is with a dying person. Much is being written about the psychiatrist in his work with the dying, but, in the main, such work is done by clergymen. Certainly, the clergyman has a unique responsibility to minister to the dying. The chaplain has many rewarding moments in such work and where he can help the patient to meet death with dignity, the chaplain often experiences a new birth of faith within himself.

Obviously, where the chaplain is dealing with the dying, he, also, has an obligation to the family of the dying. In this case, he should center upon their needs when he is with them. He can help them to face the fact of death, and he can spend time with them while they work through their grief. The chaplain should not obscure the fact of grief or the fact of death, but should strive to help the family accept such realities. He cannot become alarmed when tears flow, but should, indeed, be rather relieved, as tears are necessary. Where grief is not faced, complications can develop. It is far better to pass up the sedative and the comforting evasion of the facts and face the reality of the situation. It is estimated that effective grief work demands from 8 to 12 hours of somebody's time. Many times the military chaplain does not have that much time with the family of the patients, as they depart the post soon after death, but he should make use of the time he has. One

military chaplain serving in a Post Hospital was informed that a mother had been called in her home miles away to let her know that her son was seriously ill. (This is a standard hospital precaution.) Such notification did not mean, necessarily, that the soldier was facing death, but he was receiving special medical and nursing care, due to the serious nature of his illness. After the mother was notified, the boy took an unexpected turn for the worse and lived only an hour or two. An attempt was made to inform the mother that her son had died, but she had already left by air to be with him in the hospital. The Hospital Commander sent the chaplain in a sedan to meet the mother at the tiny field where she would land. At the field there was only a one room building to serve as a terminal. There was no place to be alone to talk. The chaplain met the mother and led her to the sedan. He then sent the driver for her bags and, thus, created a field expedient for an office in which to pass on the information. When the mother was informed of her son's death, and the cause of it, she could not accept it. After a few moments of denying aloud that it could be, the full impact reached her and she became a sobbing child. The chaplain sat with her quietly, first saying: "I know words can't help. I'll sit with you while you cry, as I know this is terribly difficult for you. There is no need to talk." He sat with her until she stopped crying, and then offered a brief prayer recognizing her feelings, but setting them in the foreground of God's understanding of the suffering human. It was her desire to go to the hospital, some miles away, and to talk to the doctor and to others who had known her son. The chaplain saw that she got to her room, that she met the Red Cross director, and then he helped her contact the people she wanted to see. Her talk with the doctor and the few facts he gave her helped immensely. She also talked to the Hospital Commander, the Commander of the unit her son was assigned to, and to representatives of the Post who advised her of certain requirements and certain rights important at such moments. The next morning the chaplain accompanied the woman to the plane, still helping her express her grief by encouraging her to talk about her memories of her son. Apparently she was in good condition when she left, and the work of mourning was already well on the way, because the chaplain had accepted the fact of her grief without turning away from her. In this case, the intensity of the first reaction was related not only to the fact of her son's death, but to the fact that her husband, the boy's father, had died of the same ailment only 6 months before. Such an experience is exhausting, but some involvement is necessary, and, thus, some suffering is involved on the part of the chaplain. During these events, the chaplain maintained control of himself, but partici-

pated enough in the grief to be experienced as one who cared. Such an involvement is necessary. To go too far, however, is to create another problem rather than solve the one at hand.

33. Summary

Work with the bereaved and with the dying is clearly the responsibility of the clergyman. The military clergyman has more than his share of such work. If he does it well, his own strength grows and his faith is renewed. What has been said here has skirted the problem of specific rites required by certain groups. Such matters are complex and become quite involved in a society made up of a multiplicity of religions. Manuals written to cover specific "denominational requirements" have been published, but often tend to perpetuate as many errors as they correct. The military chaplain in the hospital should strive to know the requirements of his own faith perfectly. He should then seek out chaplains of other faiths to talk to them about their requirements. A roster should be maintained of as many groups as are served by chaplains at the same post. Often, the list can be expanded by including civilian ministers (after contacting them personally) and chaplains of nearby military installations, until as many groups as possible are covered. Then, where the religious ties of the patient are not those of the chaplain, a minister of his own faith may be contacted.

As a training measure, there are included in the appendix of this pamphlet some actual verbatims of work with the dying. They represent the work of one chaplain with the dying, and both are examples of calls not involving the observance of ecclesiastical rites. The verbatims can be evaluated by the individual chaplain, or in groups of those concerned with hospital service, and the helpful and unhelpful elements can be discussed at length. Such case work should be sought by hospital chaplains so that groups can learn from their own mistakes. The identity of the chaplain and the patient can be veiled and a few changes made to insure anonymity where it is necessary. The army chaplain will be expected to continue to improve his ability to work with the dying and with the bereaved as long as he serves, for such is his peculiar field of interest.

SECTION XIII
THE THERAPEUTIC TEAM

34. The Doctor

a. The Role of the Doctor. In any concept of the therapeutic team within a hospital the doctor must appear as head of the team. The relationship of the doctor to the patient is one of the most carefully structured of all relationships. The doctor is related to the patient as intimately as the clergyman is to his parishioner. In many respects it is a more intimate contact. The doctor has access to every part of the patient's being. If he is to do his job well, he must know all that can be known about the patient's physical nature and his emotional makeup. The doctor is greatly concerned with how the patient is treated at home and by those with whom he lives and works. If the doctor is to function well, the patient must feel free to provide all information requested so far as he is able. The doctor may, by his careful physical examination, learn much about the physical well-being of the patient, which the patient would not know without the doctor's assistance. Yet, there is certain information which the doctor would never know unless the patient tells him.

When a doctor assumes responsibility for the physical well-being of a person, he immediately has the right of access to the mind and body of the patient so far as it is necessary for his treatment. The Hippocratic oath is, of course, well known, and the doctor is expected to perform in a highly ethical fashion. If he fails to do so, he may find his license to practice withdrawn. Since the doctor assumes such responsibility, he, also, is given the responsibility to determine what information the patient should receive. It is for the doctor finally to determine whether or not a patient should be told that he is suffering from an incurable ailment. Many times, chaplains propound the ethical question, "should a patient be told that he has, for instance, inoperable cancer?" This is interesting speculation, but the real responsibility goes finally to the head of the therapeutic team, the doctor. Doctors with experience begin to learn that the question is not so much should a patient be told, as when can you be sure that you are absolutely right in your prognostication. Humility comes with experience. The doctor may discuss such material with the chap-

lain or ask the chaplain's opinion. He may, indeed, ask the chaplain to convey information which he thinks the patient should have. However, this rests entirely with him and is not to be decided by the chaplain. In some cases, the doctor may give the family the news and leave it to them to decide whether or not the patient is told. In such instances, the chaplain may be called upon to counsel with the family as to the proper course of action. The religious requirements of the group to which the family belongs will help determine the decision. A clergyman of that faith should be called for such matters if it is at all practicable. When the chaplain is asked to inform a patient as to the serious nature of his illness, he should talk carefully with the doctor and make certain of his facts. Even then, the chaplain should not enter into a medical discussion of the patient's illness, but simply present the facts as he has them, as they relate to the patient's attitude and mood.

b. Relationship With the Chaplain. The doctor in practice today is learning that he may, also, have to form a working alliance with a minister. The medical profession does not usually fight such a relationship, but often is puzzled by it. The clergyman, working with the medical doctor, must recognize that the doctor is not going to be able to structure the role. The clergyman must work out his own concept of how he fits into the therapeutic team. The tendency of the young clergyman is to turn to the medical profession for the answers in his work with the sick. The doctor cannot provide such answers, because he does not have them. The chaplain must determine how he can best function as a man of religion in a hospital situation. The doctor will often give the chaplain free reign and judge his work simply by how it affects the patients. Where the patients respond affirmatively and their treatment progresses rapidly, the doctor is only too happy with the work of the chaplain. It is well to remember, always, that even where the doctor is willing to provide advice on the role of the minister, the minister, himself, still has the responsibility to decide what he must do. The doctor's relationship with the chaplain is that of one professional man to another. The doctor, well recognizing the fact that the emotions play an important role in healing, is usually glad to work with the clergyman. He will impart no more information than he feels is ethical, but will offer what he can in an attempt to help the minister relate his religion to the patient more effectively. In the matter of healing, the chaplain is a subordinate member of the team. In the matter of religion, the chaplain is the leader.

The doctor has a personal relationship to the chaplain in addition to the professional one. The doctor, a layman so far as religion is concerned, may turn to the chaplain for the help he can give him personally. Perhaps, it is not widely appreciated how much worry the doctor must carry on his shoulders each day. Often, when a patient dies, the doctor needs a sympathetic, understanding, professionally-trained listener. He would be more likely to utilize a clergyman for this purpose than he would a psychiatrist. If the hospital chaplain learns to make himself available to the doctors as a clergyman working with them, rather than as only another therapeutic aid, he can add to the importance of his ministry. The extent to which these relationships are developed is determined by the initiative, enthusiasm, and skill of the chaplain.

35. The Nurse

a. Role of the Nurse. One of the most important professions working in cooperation with the doctor is that of nursing. Well prepared professional nurses are greatly in demand, for, in large measure, the success of the doctor depends on the skill of his nurse. Nurses must work out and see that a schedule for treatments prescribed by the doctor is followed. They must do what they can for the person in pain to alleviate suffering, and, where the pain cannot be eased, they must do what they can to encourage the patient. The nurse must know what the patient takes into his system and what he eliminates. The nurse has many more actual contacts with the patient than the doctor or his intern does. As the doctor's representative on the scene, the nurse is invaluable. Many times, whatever the sex of the nurse, the nurse assumes the maternal role for the patient, while the doctor provides the paternal role. The nurse knows much about the person emotionally as well as physically, is sensitive to his moods, and knows how to anticipate his needs. Since the greatest enemies of the hospitalized are the feelings of isolation and rejection, the nurse, by contacts with the patient, is most valuable, for constant contacts can help alleviate both of these threats. The nurse must register concern and compassion, but must not become overly involved with the patient. Nurses must be tender and, yet, methodical and quietly efficient. Many times, the nurse will be the one ear that is available when the patient needs to pour out his inner thoughts. The relationship of nurse to patient is one of those which is emotionally charged and wherein dangers of overinvolvement are clear. The the relationship is such an intimate one, it is, also, one in which the possible values are greater than the dangers. The

nurse can add the plus value to the doctor's therapeutic program which may insure its success.

b. Relationship With the Chaplain. The nurse's relationship to the chaplain is, at least, a twofold one. In the first place, the nurse may see the chaplain as another therapeutic assistant on the doctor's team. He will be looked upon as an equal if he shows himself to be trained to perform within a hospital situation. With the chaplain as a therapeutic assistant, the nurse has an ally to contact when it is found that a person's needs are expressed in a religious framework. Nurses know when patients are feeling depressed or when elated. They know when patients have a need for a clergyman. They do not have to wait for a verbally expressed need but can see it in the emotional reactions of the patient. Probably the chaplain's greatest potential help in the hospital is the nurse who can immediately put him in touch with persons in need. The chaplain should not assume that the nurses understand the deeper implications of the patient's spiritual needs, but he can certainly appreciate the fact that they can spot the need. After the need has been spotted and reported, it is up to the chaplain to bring his skill to bear on it.

The second relationship which the nurse has with the chaplain is that of a layman to a spiritual counselor. Nurses have to function under great difficulties. Often they may have feelings toward fellow professional personnel which they wish to discuss in confidence with the chaplain, and which he can help them understand. Sometimes the problem may concern their feelings about patients, and again the chaplain is the logical person to go to about the matter. Often, the nurse's emotions are torn as the patient dies or goes through extended periods of pain. During such times, the chaplain should try to make himself available on the ward and should keep himself open to opportunities to minister to the nurse. Working together, the nurse and the chaplain can strengthen each other in their work in the hospital. Here again, it is necessary for both to observe their feelings, both towards the patients and towards one another, as intimate emotional contacts can lead to difficult involvement. Where this fact is known and accepted, the dangers can be overcome. The important thing for the chaplain is to remember to respond to the nurse's request for immediate attention for the patients, whatever his own feeling might be. If the nurse begins to find that when asked for he will come, he can be sure of being called in the hour of deepest need. However, if he does not come when called, because he does not think it is important, it may be that the nurse will not, in time of deepest need, think of calling that chaplain either. A close working rela-

tionship is required between the nurse and the chaplain if both are to be strengthened in their work with patients.

36. The Chaplain

a. The Role of the Clergyman. Early in the development of man, the man of religion assumed an importance beyond his own individuality. The clergyman, whether Roman Catholic or Protestant, or Jewish, or what, represents the unknown. The patient may also invest the chaplain with a heavy load of emotional freight drawn from past experiences. Such a relationship is quite complex.

In a time of good health and prosperity, it is typical for a person to be intellectually arrogant. If all is going well, he is not forced to face up to how little he actually knows about the forces which surround him. But when pain strikes home, or when death threatens, humility often follows. Faced with death, the human being begins to learn how little he is in command of the forces of his world. No matter how a person may have felt about clergymen before he was faced with fear, he is likely to be more open to them at this time of need. The chaplain bears with him an aura of knowledge about life beyond death, about the purpose of existence, and about the problem of suffering. Personally, the chaplain may feel that all of these are open questions and that God alone has the answer, but, whether he wants to or not, to the patient he will appear, at least in part, as a "man of magic" intimately related to unseen forces. The patient interprets the chaplain in such a way, whether he intends to do so or not. Even those patients who have prided themselves on being "scientifically" minded unconsciously see the clergyman as a "man of magic."

In addition to the role which the chaplain carries from the dawn of life, there is the role which he occupies due to the experience of the person he is seeing. The patient in the hospital responds to the chaplain, in large measure, in accordance with his early experiences with authority in general and the Church in particular. Some of these experiences may not be available to the memory of the patient, for they may be embedded in his past. The patient, also, responds to the chaplain somewhat as he responded as an infant to his father. The chaplain is a "father" figure. He represents authority figures from the patient's past. Where the patient has had specific difficulties with clergymen, these tend to be projected on the chaplain. Thus, he must be aware that when the patient responds to him he does not respond to him only as an individual. In the first place, the patient responds to him on the basis of the unremembered, unconscious experiences of the race.

In the second place, the patient responds to the chaplain on a basis of experiences in his own life, which may or may not be at the conscious level. No matter how much of an individualist the chaplain feels himself to be, no matter how liberal he assumes himself to be, no matter how cut off from tradition he thinks he is, the chaplain in the hospital soon finds that he cannot break with the time-honored role of clergyman. Indeed, if he makes wise use of it, such a role may be the strongest ally he has.

It is true, also, that the chaplain as an individual can begin to invest his role with new meaning to the patient. A hospitalized person may find his first opportunity to relate warmly to the Church. After his experience in the hospital he should not be more dependent on the hospital chaplain, but should be more open to his own chaplain and to the Church in his own community. The chaplain does not win people away from their faith; rather, he makes it possible for them to have a more significant life within that faith.

The question of role is one which is very difficult. It would be well for the hospital chaplain to read as widely as he can in psychological literature dealing with how authority relationships may be conditioned by past experiences. Such a subject could not be covered in these pages, but should remain a field of individual research for the hospital chaplain. In passing, it might be reemphasized that the one choice the chaplain does not have is that of putting aside the ecclesiastical role completely.

b. Relationship With the Patient. The chaplain's relationship with the patient is actually a multifarious one. In the first place, the chaplain's relationship with the patient is one which therapeutically is subsidiary to the doctor. The patient knows that the doctor is in charge of his case and tends to see the hospital chaplain as a representative of the doctor. This becomes evident when the patient begins to ask the chaplain what the doctor is planning next and what he can expect, and, also, when he tries to get the chaplain to talk to him of his medical diagnosis.

The patient can, also, relate to the chaplain as a clergyman in his own right. Certainly, if the chaplain is skillful and compassionate, he will step out of the role as the doctor's agent and become, first of all, a clergyman. The patient may see the chaplain as a contact with the outside world. Particularly, where the patient has had a rich life in his Church, he may see the chaplain as a bridge to life in better times, both before and after his hospitalization. The patient may see the chaplain as a "father confessor," as a counselor, as a trusted friend, as a catechetical instructor, or in other functions.

The important thing for the chaplain to recognize is that while he has a function as part of the therapeutic team, his greater role is as a clergyman. Anything which the chaplain can do to impart to the patient a more healthful attitude towards life and its challenges is most important. The relationship is an intimate one. Pastoral work in the hospital allows the clergyman to go deeper into the lives of his people than would be possible in ordinary parish life. As clergyman, chaplains must remember the great privilege that is theirs when they are allowed to enter into the life of a person in such a trying time.

c. The Chaplain as a Member of the Team. The chaplain is most valuable when he cooperates with others who are, also, dedicated to the welfare of the patient. Something has been said of the chaplain's relationship to the doctor. He should see the doctor as the head of the team as well as a human being who needs spiritual help. The chaplain appreciates the enormous demands that are placed upon nurses and strives to help them with their feelings. He, also, sees them as possessing knowledge which he must get from them. He works with the nurse as a sibling in the therapeutic family. Both look to the doctor in the role of "father," and themselves as family members engaged in the same purpose. The chaplain in the hospital environment is not alone. He gains needed assistance from his contacts with all ward personnel. The point is that the chaplain is one of many on a team at work for the welfare of the patient. Certainly, he is an individual and should not revise his scale of values as he works with the team, but he can recognize the ways in which he needs to change to improve his own work. The ways in which he can further his own work, more often than not, are those which are helpful in accomplishing the mission of the team.

37. Other Aspects of the Team

a. Other Hospital Personnel. There are many trained and dedicated persons working in a hospital environment. The chaplain should know the psychologists, the social workers, physical therapists, occupational therapists, the dieticians, and all ward personnel. Many times, he will be called in on a case due to a referral from someone else who has direct contact with the patient. It may be that the occupational therapist notes that a patient does not seem to be able to relate to others. She may sense certain depressive elements in the way the patient handles his work and may then call on the chaplain. If the chaplain shows his willingness to cooperate with others in the hospital, many similar referrals will be made to him.

Not only may the chaplain find, for instance, that he can help a patient with whom one of the social workers is working, but he may find, also, that he is able to minister to the worker. In a hospital environment the tragic situations are many and wherever emotional conflicts are emphasized, the chaplain is useful. Most workers in the hospital learn early to handle the responsibility involved in their own tasks. But even the experienced worker finds in moments of fatigue, or when difficulties are many in his own life, that the ordinary day becomes unbearable. At such times, these persons are certainly open to the help they may receive from a clergyman. So the chaplain works as part of the team, cooperating with it in its total work, but he also remains available as a spiritual adviser to any member of the team. Obviously, so many responsibilities make great demands on him. He must keep his own religious life vital, for without God's help he cannot carry on.

b. Interdisciplinary Training. The hospital is an educational milieu, even as it is a therapeutic one. The minister can learn much about the effects of physical illness on the emotions of the patients by his work with the doctors. He can learn a great deal about how people respond to difficulty if he keeps open to the psychologist and the social worker as well as the psychiatrist. Much can be learned from personal contacts with the people involved and much can, also, be learned by using wisely the case conferences held within the walls. In case conferences there is an interchange of ideas across disciplines which can be most valuable for the chaplain. He certainly will be able to take many ideas from such situations, but he should, also, strive to be ready to provide ideas which may be helpful to others. Medical personnel are quite accustomed to borrowing insights from others. Usually they are not averse to having their work exposed, as their training so conditions them. The person whose insights are carefully based on close observation is listened to. By the use of case conferences and other contacts with hospital personnel, the chaplain can grow as a knowledgeable person. He can, also, see wherein his religious insights are most valid. His own faith is continually subjected to questions arising from the traumatic experiences which are part of the day's work in the hospital. There is no greater university of life than a large hospital, but it is not enough simply to be enrolled in it. The chaplain must become active in it. He must not let himself be segregated so that he goes about his own work without making contact with other workers. It is up to the chaplain to make the best use of the environment in which he works, and as he makes good use of the environment he will find that those with whom he works receive greater help from him and from the God he represents.

SECTION XIV
MISCELLANEOUS MATTERS

38. Relationships With Command

The efficient hospital chaplain identifies himself as a part of the hospital commander's staff. He seeks to have himself included in all staff work pertinent to his section. Since most work in the hospital does involve the chaplain, this means that the hospital chaplain will be consulted in most planning.

If the chaplain identifies himself as a part of the commander's staff, he is utilized. The commander calls on him much more often than if he had kept to himself. The chaplain must be prepared to be used more fully. By working in close relationship to command the chaplain can find out information bearing upon the emotional welfare of the patients. The chaplain can know in advance what morale problems are likely to occur and can make suggestions to alleviate some of the expected difficulty. The chaplain can, thus, make his work with the patients more effective if he functions not only as part of the therapeutic team, but as part of the staff.

A close command relationship works two ways. Not only does the chaplain gain information, but he is able to advise the commander of what is going on in the chaplain's department. The commander can offer advice and assistance if he knows what the chaplain is striving to do. When other members of the staff are also consulted, they tend to see the chaplain's program as their program and, thus, are more willing to cooperate with him.

It is true that an active, aggressive chaplain will be quite busy. It is true that, many times, he will be asked to do things which he cannot relate directly to his calling as a clergyman. But it is also true that these hazards must be faced if the chaplain is to be an effective working part of the therapeutic environment, which is the hospital.

39. The Chaplain's Work Plan

It is not enough to do an effective job each day. To be really effective, work should have continuity. The chaplain must plan ahead to take care of the needs of the patients. A work plan makes sure that he has the necessary time available for emergencies.

a. To insure continuity the hospital chaplain should develop an operating procedure. This operating procedure will assign clear responsibility to other members of the chaplain's department, so that all needs are met systematically. The operating procedure should provide for coverage 24 hours a day, 7 days a week. As individual situations are different, each hospital will have different requirements for the chaplain to meet. These requirements may be similar, but the differences make it impossible to be specific in a pamphlet of this nature. Suffice it to say that the chaplain must analyze the requirements of his assignment and make a clear designation of responsibility. This designation of responsibility should be spelled out on paper so that in his absence work may go on as usual, whether he is transferred, or simply is to be absent for a short time.

In designating responsibility the chaplain considers routine coverage of the wards, emergency coverage (making arrangement for coverage by specific faiths), and the admission of all new patients. Most chaplains plan to contact all new patients and make available to them a schedule of services for the hospital. With the schedule of services, he may include other information as to how the chaplain may be contacted in case of need. With such information the chaplain, if he knows the specific faith of the patient, can include pamphlets and other pertinent literature which he feels might be valuable. It is important that the new patient be informed as to the availability of the chaplain and his intension to be of service. In hospital situations the chaplain should provide, also, for a systematic coverage of patients who are being discharged. Some arrangement should be made for those who wish to continue in an outpatient counseling relationship with the chaplain. Appointments should be set up and observed faithfully. An operating procedure should include a system for recording contacts with patients. A card file should be kept with room to include notations as to each contact with some indication of followup required. Should a patient be discharged from the hospital, but desire to continue in an out-patient counseling relationship, the card could simply be transferred to the card system for outpatients instead of to an inactive file. Such systems should identify the patient and his location in the hospital and provide information necessary to insure his religious coverage. They should also be worked out to provide a running commentary on the individual case. Sometimes case notes are better kept separately. It this is done, the file card should indicate where the case notes are kept. Care should be taken to provide a security system that will insure the confidential nature of material obtained under the rights of

privileged communications. Only the chaplain, himself, should have access to such notes.

Provision should be made for services of worship for Protestants, Catholics, and Jewish personnel. Other denominational services may be provided as required and if practicable. Such a schedule should be carefully coordinated so as not to interfere with the routine of hospital treatment. Services should come at times which make it possible for the largest number of patients and hospital personnel to attend. The number of services scheduled will vary in accordance with local needs and the number of chaplains available. Care should be taken to provide for patients whose illness requires that they be isolated to prevent the unnecessary spread of disease. Special services of worship should be arranged for such people where at all possible. These matters and others, as dictated by local needs, belong in the chaplain's operating procedure.

After organizing his coverage on paper, the chaplain should send his suggested operating procedure through the hospital commander's staff. When he does so, he makes it possible to receive helpful advice from other persons who share the responsibility of the hospital's mission. Many of the persons on the staff will have had more experience in the hospital than the chaplain. The chaplain should be willing to accept constructive criticism just as he, also, should be willing to take a strong stand for what he thinks is absolutely essential to his work. In exposing his operating procedure to the critical view of the hospital staff, the chaplain encourages a new sense of cooperation. When men are asked for advice it is natural for them to take a more pronounced interest, as the work of another becomes, in a sense, partly their own.

b. The Hospital Detachment. The hospital chaplain often has a direct responsibility for chaplain coverage not only for patients, but also for the unit which operates the hospital. He is called upon to provide character guidance, personal counseling, and other services for the hospital unit. In his contacts with the detachment, the chaplain learns something of the problems of hospital personnel. The chaplain can be of assistance and in so doing will make friends for his own work. Where he is conscientious in his contacts with the hospital detachment, the awards are far greater than the energy he contributes. The chaplain is also concerned with the families of hospital personnel and will make himself available to them, where at all possible. Work with the hospital detachment should not be left simply to duty assignments such as character guidance or the provision of services of worship. The chaplain should maintain contact with administra-

tive personnel throughout the week. Brief visits in the orderly room will be appreciated and will insure that the chaplain is available when he is needed. Since the work with the detachment is, in many ways, similar to the chaplain's assignment in any unit, no more will be said in this pamphlet as to his specific duties.

40. Cooperation With Other Chaplains

a. Hospital Chaplains. Hospital chaplains must learn to work smoothly with other chaplains on the therapeutic team. Protestant, Roman Catholic, and Jewish chaplains have common administrative problems requiring coordination. A departmental staff meeting should be set, at least, weekly, with provision for the calling of other meetings, as needed. Such meetings should be as brief as possible but should provide an opportunity to consider problems of hospital morale, religious coverage, character guidance scheduling for hospital personnel, and other matters of mutual concern. Such conferences also provide an opportunity for a comparison of notes regarding work with individual patients, where such does not involve the compromising of confidential material. Chaplains working in the hospital milieu should develop a willingness to seek objective opinions of other professionally trained clergymen. Much of the work connected with the counseling of patients is of such a nature that it can be discussed across faith lines. The building and the utilization of a professional relationship with a patient is a matter of interpersonal relationship, largely, and does not necessarily involve ecclesiastical matters not properly a matter of consideration for those outside the faith. Nothing that is said here is intended to break down ecclesiastical barriers, but, rather, to encourage the same type of objectivity the hospital chaplain observes when he attends medical case conferences.

b. Unit Chaplains. Hospital chaplains should know as many of the other chaplains assigned to units in the same area as is possible. They should have information as to the various denominations represented should referral, for religious purposes, be necessary. If the Post has a duty roster for after hours coverage at the hospital, provision for exchanging information should be made. The duty chaplain should contact the hospital chaplain on reporting and before being relieved from duty. Where there are sufficient chaplains assigned to the hospital to provide emergency coverage it is best to utilize them and avoid the possibility of conflict with others not so assigned. However, sometimes supplementation must be made. In such cases, the good will of all concerned is important.

Unit chaplains should be notified when their personnel are hospitalized. Despite the best of operating procedures, some emergency admissions occur in such a way that the unit chaplain learns about them too late to be of service to his people. The unit chaplain should be urged to contact the hospital chaplain directly when he comes to visit in the hospital. It is a matter of courtesy, and, often, needed information can be exchanged. For the welfare of the patient, unit chaplains should be encouraged to visit their men regularly, as such chaplains can be a bridge to the outside world. The hospital chaplain cannot perform that function as well. No jealousy need develop, since a good hospital chaplain will not win men away from their own chaplains, rather he will strive to make it possible for them to work more helpfully with their unit chaplain when they are discharged. When there is a healthy relationship between the chaplains assigned to the hospital and those assigned to other units in the area, the welfare of the patient is enhanced, and such should be the goal of all concerned.

41. Personal Qualifications

a. Physical and Emotional Attributes. The hospital chaplain occupies a demanding job assignment. He must be physically well enough to maintain his emotions on an even keel, even though he sometimes works around the clock. It is not an easy matter to offer coverage to an entire hospital with the chaplain personnel now made available. The chaplain is on his feet many hours. He is called upon to assist emotionally distraught persons when he, himself, is working on the edge of fatigue. Such work cannot be done by anyone in less than good health. Too often, assignments have been made to hospitals on the basis of the fact that the chaplain concerned was unable to carry on full duty with his unit. If a chaplain is not able to carry on full duty with a unit, the chances are he cannot perform adequately within a hospital situation. A hospital assignment is no rest cure.

The chaplain should be both physically and emotionally in good health. He must be in command of himself if he is to be of assistance to others who may have succumbed to the heavy emotional burdens attendant upon hospitalization. The chaplain should be calmly optimistic, hopeful, but not overly aggressive with his good spirits. He should be well-balanced, able to keep his personal problems from influencing his contacts with others adversely, and willing to accept the continual responsibility that goes with the work with the hospitalized.

b. Training Requisites. Preferably, the chaplain should have had, at least, 1 year of clinical work within a medical installation. Such work should have been carefully supervised and should come

up to the standards of any of the recognized clinical training programs. The best possible training for hospital work is for the chaplain to perform under tension with the advantage of the objective view of a supervisor. Hospital work cannot be learned out of textbooks or pamphlets, although a careful reading program is important. The chaplain should be willing to place himself in a hospital situation under observation and should be mature enough to be able to learn from careful, critical evaluations of his work. As the chaplain begins to see how his feelings are involved in his work he gets a better picture of his capabilities and his limitations.

If it is impossible to provide a chaplain who has been specifically trained for a hospital assignment, then an attempt must be made to find a man who has had some experience in the work even if it has not been supervised experience. Some men can learn quite a bit from performing on their own within a hospital. Past performance gives some indication of their capabilities. In making assignments to key hospital positions every attempt should be made to provide the best man possible. If there is no one available who has had supervised clinical training or who has performed for some time on his own in the hospital situation, then the requirement should be that the man considered be interested in the assignment and be willing to use it as a learning experience. Where psychological testing is available it can be used as an indication, if it is used carefully by experienced men. It should be clear that the candidate for the hospital assignment is not seeking to use the hospital simply as a way of finding help for his own pathology.

c. Classification and Assignment. While each chaplain must be available for any type of duty assigned to him within the military it is clear that some develop certain skills more so than others. Where a chaplain has demonstrated his ability to function within a hospital situation some record of this should be kept. Ordinarily, the chaplain who does function well with the hospital will function well on any chaplain's assignment. The more effective chaplains are ready to perform on any job. Perhaps, within the Chaplain Branch there are not enough men to arrange for specialization, yet each man should strive to become an expert on his present assignment. In civilian institutions the requirements for hospital chaplains are becoming more and more professional. It is hoped that the military will be able to keep pace with the civilian institutions and be able to provide a trained man for every key assignment. Certainly, at the Army medical centers there should be, at least, one chaplain who has received a year or more supervised clinical work so that he may plan for the training of those who work with him to qualify them for later assignments.

SECTION XV
CONCLUSION

42. A Final Word

One of the most important assignments that a clergyman can have is to work within a hospital environment. Within the hospital the tragic situation is the common one. Although the experience of working in a hospital is lightened by the many therapeutic successes one observes, one spends much of his time in situations that are not so promising. Within this pamphlet an attempt has been made to alert the chaplain to many types of problems which he will meet. Certainly, not all problems could be included within the scope of this pamphlet. Yet, an attempt was made to incorporate enough material to provide general principles sufficient for the meeting of most problems which may come up.

No work can be more rewarding or more demanding than hospital work. The demands may be part of the reward, as the conscientious chaplain will find himself growing in ability and emotional poise as he works. The place of religion in a hospital is clear. The modern hospital arose from religious motivations and functions, at its best, in full cooperation with the forces of religion. A hospital chaplain's responsibility is to make religious forces available and effective in carrying out the mission of the hospital to promote the health of its patients. Health includes not only soundness of body and mind, but, also, soundness of attitudes and emotional life. The clergyman has a great contribution to make in the work of the hospital.

Administrative demands vary according to each institution. Yet, pointers have been provided which, if applied, should help a chaplain to see more quickly the needs of his particular assignment and how to go about meeting those needs. In the medical profession, education is an on-going process; the medical doctor never learns enough. The chaplain who is working in conjunction with medical personnel should share the same attitudes towards learning. He should seek to have his techniques criticized and his work evaluated. He should invite questions from other disciplines. He should want to work more cooperatively with others. If he has such an attitude towards his own education he can become of great value to the healthy, the sick, and the dying.

If the pamphlet has provided principles for developing an effective program within a hospital, it has met a portion of its purpose. If the pamphlet encourages the chaplain to find new training opportunities, it has been even more valuable. The demands of hospital work are many and varied, and the chaplain has to draw on the full resources of his faith if he is to measure up to his assignment. This pamphlet has not gone into the special ecclesiastical demands of the various denominations. It is expected that each chaplain will know the requirements of his own faith, or will strive to find out all that he can about them. Yet, if the human contacts are handled well, the ecclesiastical rites will be made more meaningful to the patient. So let each chaplain administer faithfully the demands of his own faith without violating the religious views of the patient. Conversion is not the goal of hospital work; it is rather to help the patient within his own framework of faith. First, let the chaplain meet the needs of each individual so far as he is able, and then let him make referral to a clergyman of the particular faith involved. "Conviction without compromise" works in a hospital environment as it works on the battlefield.

APPENDIX I
OUTLINE FOR VERBATIM

A suggested outline for a verbatim report is as follows:

I. Statement of the Situation

What was in the room or near the bed? Were cards or flowers displayed? What about the personal appearance of the patient? Did the patient seem tense or relaxed? Was he apparently cheerful or sad? Was the patient lying down or sitting up? Any other details that might cast light on the call.

II. The Conversation

Note what the patient said (in his own words, if possible) and how the chaplain responded. Note verbal and nonverbal responses. Note the length of any pauses. Leave a wide margin for the conversation as reported, so that the chaplain, or his supervisor, if he has one, can enter critical comments later.

III. An Evaluation

The chaplain's understanding of the patient's needs, and how the chaplain thinks he might be of help. Does the chaplain feel the call did help the patient? In what way did it help? If not helpful, the chaplain should state why he feels the patient was not helped.

Writing and evaluating reports of hospital visits can make the chaplain increasingly valuable to the patients. The chaplain can learn how to listen in such a way as to help the patients find strength within themselves to cope with their own problems. He will learn how to summon the resources of the hospital to assist the patient. Finally, and most important, the chaplain can learn how to help the patient use the resources of religion so that the patient is helped no matter what the physical outcome of his hospital stay may be.

APPENDIX II

VERBATIM OF VISIT WITH DYING PATIENT

Conversation With Dr. C

Dr. C is in terminal phases of cancer. Has had operation severing nerves from spinal column for some ease. She has been in much pain constantly for about a month in the hospital. She was placed on the list as critically ill the day before this visit. She is an elderly doctor who has done much good in the community for many years. She is unmarried. The chaplain has been in almost every day, but often finds her out of contact. When she has been awake she has requested prayer, and once said, "I never realized it would take so long." On this visit the chaplain found two relatives in the room with her. They said, "She has been rambling quite a bit. Dr. A was into see her and left although I could tell she didn't want him to leave. She may be glad to see you." They left, and the chaplain approached the bed. Dr. C had her eyes wide open in what appeared to be a sightless stare, although she was aware that someone had approached her bedside.

P. Ohhh. Ohhh. Ohhh. My how it hurts.

C. You are having a hard time of it.

P. What?

C. You are having a hard time of it, I know.

P. Ohh yes.

C. Don't feel you have to talk with me. I'd like to sit here with you for awhile.

P. All right. (very faintly)

C. (Sits for a time. P moves her head from side to side moaning as though in intense pain. Finally, after a long pause, C speaks) It must be very difficult for you.

P. I never dreamed it would be like this. Ohhh. Ohhh.

C. (After long pause) Would you like for me to offer a prayer before I leave.

P. (Seemingly understanding this) Oh yes.

C. Father in heaven, God of the still waters, God of quiet strength sufficient for all things, to Thee we turn. We thank Thee for Thy love. Be Thou with this one in her time of pain and comfort her as only Thou canst comfort. Oh shepherd God, God of the lonely ones, help us to know that Thou art with us now and

evermore, in Christ's name. Amen. (Pause) Well, I'll be going now, Dr., and I'll be back again.

P. Let me tell you something. (C bends over bed to hear more easily) There is a man with a bomb. He is going to blow up the apartment house. He will kill many people, children and all. There is a cablegram already made out saying "Save the reborn." It is in that desk. It would be easy to do this. I could commit suicide, but it is a weapon that would be used on others. I wouldn't do that. I wouldn't do that.

C. You wouldn't do that.

P. No. I couldn't. It would be easy to and he is going to do it. I can't stop him. I wish I had known about this when I came in here, but I didn't.

C. You'd like to stop this man with the bomb?

P. Yes I would.

C. What is his name?

P. I don't know. I wish I did, but I don't know.

C. I'm glad you told me this, and I'll remember this. I'll leave now and come back later.

P. I'm glad I told you. I'm glad you are aware of this. It makes me feel better.

C. Getting this off your mind made you feel better?

P. Yes it did. Save the newly born. Save the newly born.

C. Well, I hope you have a good night. I'll be back later. (C walked toward the door)

P. (Louder) It didn't do a bit of good.

C. (Back at bedside) It didn't help?

P. No. It didn't change things, just my telling you. A man who'll perform a heinous crime like that would do anything. Just talking wouldn't stop him.

C. I'm glad you told me anyway. You can trust this to me.

P. (In pain) Ohhh. Ohhh.

C. Goodby now, and God bless you.

C left the room.

Summary. P had her eyes opened all during the call, but did not appear always to be seeing the visitor. She was quite agitated in passing on the information about the man with the bomb. It appeared to the chaplain that P was expressing her own death wishes, which would be understandable in the midst of such constant and prolonged pain. She may have been saying that she would like to destroy herself but she knew that this was not acceptable to society and would be a threat to others. Her desire to take her own life may have been projected onto the figure of

the man with the bomb. The social repercussions might here be expressed in the symbol of the bomb destroying the innocent also. Her stress on "Save the newly born" or "Save the reborn" may come from the fact that she had a long career in the practice of obstetrics. It is C's opinion that she feels her life is finished, she wants to die and leave the world to the newly born.

In this case delusional material is illustrated. The delirium may have come from drugs. The chaplain did not handle the intellectual content as he was aware of the reality picture. He tried to accept her as a person in torment and worthy of respect and compassion. Did he succeed?

APPENDIX III
VERBATIM OF VISIT WITH DYING PATIENT

Conversation With Mr. Y

Background: Mr. Y, the patient, has had multiple myeloma for about 3 years. It is a blood ailment in which the bone structure slowly is eaten away. Much pain is involved. Patient has been hospitalized often for fairly long periods and has carefully recorded the development of the disease for research purposes. The chaplain had heard of the readmission, and had seen the patient in the hall in a wheelchair, and had, thus, already renewed a previous acquaintance. As the chaplain came into the room, the patient was sitting at a table, and was checking some papers.

C. Good afternoon, sir. I just thought I'd drop by and see how things were going.

P. (Rather abruptly) You can stay about 3 minutes, until they come for me. I have to go for a test. (Pause) This time I'm really bad off.

C. Worse than the last time?

P. It was bad then . . . it has been bad a long time.

C. I know you have gone through a lot.

P. This time I've had such pain. I stand pain well, but this has been so bad. (Pause) This thing has spread all over me. Six ribs are eaten through. Even my skull is affected. My pelvis . . . all over.

C. It is really bad.

P. And this time I've some other information they don't know I have. I read a report from my X-ray man in Blanksville to my Medical Doctor . . . and it is bad.

C. Have you told your Doctor you have this information?

P. He knows it now. I told him to read the report there in the desk drawer. He knows I know it. I told him he could make a copy of the report if he wants to. (Pause) You know I have to make a decision about a new medication. The doctor wanted to keep me off of it for another year, but with these new developments, they want to start now. But I have to decide . . . this decision may involve my life.

C. You have a very difficult decision to make.

P. Yes, I do . . . and I have some hope, but little faith. There is a difference you know. I am an agnostic. I don't know . . . and I admit it. I hate hypocrisy. I just believe that God, the great architect, the supreme planner, is all knowing, all powerful, all loving, all forgiving.

C. No matter what you call God, this is what He is to you?

P. Yes, that's right.

C. I can understand your feelings. I don't like hypocrisy either. I don't care for those who try to say too much.

P. Also, I've some other bad news. When I came in this time I found that my friend, Mr. X, was here in the hospital. He is one of my fellow sufferers. I know several of them who come here off and on. I called on him, and while I was there I asked him about Mr. H, whom I had known when I was here in June. He told me that Mr. H was fine. He had gone home. I was happy about that.

But then, the next morning, just as Mr. X was leaving to go home, his wife came by to see me. She said, Joe couldn't take this, but I thought you could and that you should know. Mr. H is dead. He died just a few days ago and we didn't think we should tell Joe. But you've always handled things so well, and I felt I ought to tell you. (Pause) I'm still wondering if I'm glad she told me. You see, H was on the same medication they want me to take. (Pause) I almost wish she hadn't.

He paused a moment and then said, almost angrily, What the hell are they so late for? He called the ward desk on the intercom and complained about having to wait. There was a brief interchange of statements.

Before the conversation could be taken up again, an intern came in to inject a dye into P's veins. Very politely, the intern said, Excuse me please. This will only take a minute.

After the doctor left, the chaplain waited quietly for the patient to begin. P, obviously nervous and outwardly disgruntled, said, Will you excuse me now?

C. Certainly.

P. Close the door please.

C. Of course; he left and closed the door after himself.

Evaluation: With the first word of greeting, the chaplain felt that the call would not be a valuable one. He remained standing, and was surprised that the patient immediately went into such a traumatic area. The call took on a deep import from that time forward. The chaplain felt that he reflected fairly well on the feelings of the patient, and let him develop significant matter

with ease. Yet it appeared that the patient went farther than he had intended to go and lost his control. When the patient realized how much he had said, and how much feeling he had expressed, being a person who likes to have command of himself and the situation, he reacted in anger. It is felt that this was hostility toward the chaplain and only indirectly turned against the ward for the lateness of the test. Thus, he could express anger without turning directly upon his visitor. After the break in continuity, the patient felt, evidently, uncomfortable with the situation and gained control only by asking the chaplain to leave.

I suppose the call was more valuable than harmful.

My analysis of the situation has not proved accurate. It was my feeling that the patient could be best helped by continued calls until he was ready to deal again with dynamic questions. Although there may be truth in this, thus far the patient has deliberately warded off the moments alone with the chaplain. If they are caught alone, the patient defends himself by asking many point-blank questions of the chaplain, and then, when finished, asking him to leave.

This case involved a man who had built up defenses to avoid facing death. He had done this over a period of years. Yet suddenly they started to crumble and he began to face the facts. The facts were too much for him and he had to retreat to his defenses. In such cases it may be necessary to accept the defenses and let the patient stay within them. Anything more was too much for this man. His recognition that he has gone too far is evident in the anger he expresses toward the ward personnel. In later contacts Mr. Y was more careful and the chaplain was never able to be of real help. What do you think the Chaplain did wrong? Criticize and evaluate.

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